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MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN SERVICES

AND THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

AUGUST 3, 1989

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MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS

THURSDAY, AUGUST 3, 1989

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING, AND
SUBCOMMITTEE ON HUMAN SERVICES,
OF THE SELECT COMMITTEE ON AGING,
Washington, DC

The committee and subcommittee met, pursuant to notice, at 9:35 a.m., in Room 345, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the Select Committee on Aging), and Hon. Thomas J. Downey (chairman of the Subcommittee on Human Services) presiding.

Present: Representatives Roybal, Downey, Hughes, Clarke, Kennedy, Bilbray, Jontz, Staggers, Pallone, Unsoeld, Snowe, Schneider, Bentley, Fawell, Schuette, and Morella.

Staff Present: Manuel Miranda, Staff Director; Gary Christopherson, Director of Health Legislation; Yvonne Santa Anna, Professional Staff; Valerie Batza, Executive Assistant; Sue Williams, Congressional Intern; Paul Schlegel, Minority Staff Director, and Ron Hindle, Minority Research Assistant; of the Select Committee on Aging.

John Olinger, Staff Director; Moya Benoit, Research Assistant; and Natalie Cannon, Minority Staff Director; of the Subcommittee on Human Services.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Mr. ROYBAL. The hearing will please come to order.

The purpose of today's joint hearing is to examine the mental health problems of America's elderly in nursing homes. This hearing will consider what actions are needed to ensure mental health care access and quality of service currently unavailable in the nursing home setting.

The lack of mental health services for the elderly who are patients in nursing homes is an immediate and growing concern. It is our understanding that there are approximately 1.3 million elderly nursing home residents. Data from the National Institute of Mental Health shows that 668,000 people with serious mental health problems currently live in nursing homes—and that's about 50 to 60 percent of all residents in these facilities. Approximately 72,000 of these patients are solely placed in these settings as a result of mental illness with no accompanying physical disability.

Mental disorders among nursing home patients are frequently undiagnosed, some are misdiagnosed, or diagnosed in such a manner that treatable disorders are not recognized.

For far too long, mental health care has been a neglected priority in our American health care system. This neglect and atrocity must be addressed by Congress. Too many elderly, as well as nonelderly Americans, need our help.

On January 3rd of this year, I introduced "The Mental Health and Aging Act," which is H.R. 111. This legislation lays the foundation for an expanded Federal mental health effort in three critical areas: (1) the development of an effective mental health service system to adequately care for elderly persons; (2) the modification of Medicare and Medicaid mental health service coverage and cost containment; and (3) improvements in quality assurance and access protection.

That is in general what we find in that bill, 111. We hope that today we can get some answers to some of these questions.

We want to know for sure how many elderly patients there are in homes throughout the Nation; whether or not it is true that they're being neglected. And if so, what recommendations do you have for Congress to to remedy the situation?

These are in general some of the reasons why we're holding this hearing, and why we've asked experts in the field to make a presentation to members of this committee.

[The prepared statement of Chairman Roybal follows:]

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

OPENING STATEMENT

"MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS"

House Select Committee on Aging Hearing and

Subcommittee on Human Services

9:30 a.m., Thursday, August 3, 1989
345 Cannon HOB, Washington, D.C.

PURPOSE: The purpose of today's Joint Committee Hearing is to examine the mental health problems of America's elderly in nursing homes. This hearing will consider what actions are needed to ensure mental health care access and quality of service currently unavailable in the nursing home setting.

The lack of mental health services for the elderly who are patients in nursing homes is an immediate and growing concern. Currently, there are 1.3 million elderly nursing home residents. Data from the National Institute of Mental Health shows that 669,000 people with serious mental health problems currently live in nursing homes -- some 50 to 60 percent of all residents in these facilities. Approximately 72,000 of these patients are solely placed in these settings as a result of mental illness with no accompanying physical disability.

Mental disorders among nursing home patients are frequently undiagnosed, misdiagnosed, or diagnosed in such a manner that treatable disorders are not recognized. This problem is compounded by two other variables.

First, there is a serious shortage of trained geriatric mental health professionals within the United States. Psychiatrists, psychologists, social workers, and nurses all have a potentially important role to play in the treatment of mental health problems in elderly persons, but only a small proportion of practitioners in any of these disciplines have as yet been specifically trained to work with the elderly.

Second, Medicaid and Medicare reimbursement policies promote inefficient, expensive, and often inadequate care for the mentally ill. Though there have been recent improvements, Medicare psychiatric benefits are still outmoded and markedly inferior to benefits for physical illness. In the case of Medicaid, nursing homes can lose their eligibility for Medicaid reimbursement if more than 50 percent of their patients are being treated for a mental illness. Consequently, nursing homes have incentives to avoid elderly persons who are diagnosed as mentally ill for fear of losing a significant funding source.

For far too long, mental health care has been a neglected priority in our American health care system. This neglect and atrocity must be addressed by Congress. Too many elderly as well as non-elderly Americans need our help.

On January 3, 1989, I reintroduced "The Mental Health And Aging Act" -- H.R. 111. This legislation lays the foundation for a strong and expanded federal mental health effort in three critical areas: (1) the development of an effective mental health service system to adequately care for elderly persons; (2) modification of Medicare and Medicaid mental health service coverage and cost containment; and (3) improvements in quality assurance and access protection.

It is time that members of Congress come forward and support significant reform of federal mental health related laws. We must protect both the elderly and non-elderly Americans from the devastating effects of mental disorders. I look forward to the testimony being provided by our expert panel, as I look forward to a long awaited improvement in mental health services in nursing home settings.

Mr. ROYBAL. The Chair now recognizes the Cochairman of the hearing, Congressman Downey.

OPENING STATEMENT OF CHAIRMAN THOMAS J. DOWNEY

Mr. DOWNEY. Thank you, Mr. Chairman. Thank you for your leadership in this area. Clearly there is a problem here and what to do about it is part of the reason for this hearing. I've been involved in this issue for many years, predating my years in Congress—my mother works in the State of New York in the capacity of geriatric coordinator for our State. And this has been a subject of discussion in my family for all the years that I can remember. I'm pleased that personally I was able to play a role in trying to take mental health services in Medicare out of the dark ages that it currently exists in. A few years ago, it was my bill that was passed that increased the outpatient mental health services from $450 to $1,189.

We still have the absurd situation where mental health services are dealt with differently from physical health services under Medicare and, hopefully, some day that is something we can remedy.

But in the meantime, we have much to learn and much to do, and I appreciate the Chair's calling this hearing.

I ask unanimous consent that my formal statement be included in the hearing record, and I await anxiously the testimony from our very fine panel.

[The prepared statement of Chairman Downey follows:]

STATEMENT OF THE HON. THOMAS J. DOWNEY

CHAIRMAN, SUBCOMMITTEE ON HUMAN SERVICES

JOINT HEARING ON

"MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS"

August 3, 1989

9:30 A.M.

345 Cannon

As the Chairman of the House Select Committee on Aging's Subcommittee on Human Services, I am pleased to be here today to co-chair this hearing on Mental health in Nursing homes.

The focus of this hearing is the lack of adequate mental health services for our Nation's 1.3 million nursing home residents, the barriers encountered in providing those services and possible solutions. There is no doubt that, despite their documented need for mental health services, older adults are shortchanged by the mental health system.

A national survey conducted four years ago found that nursing homes were housing 855,270 mentally ill patients over the age of 65, or 96% of all such people placed in long term care facilities. About 70% of those people were diagnosed with Alzheimer's disease. A review of patient records found that only 5% of patients had documented contact with a mental health professional.

Psychiatric intervention can reduce physical morbidity as well as the dollar costs of medical or surgical care for elderly patients. When ambulatory mental health services are offered, the use of other means of health care is reduced. However, for too long, the mental health care needs of the elderly have been unmet.

While we know that 15 to 20 percent of older Americans have significant mental health problems, senior citizens receive only 7 percent of inpatient psychiatric services, 6 percent of community mental health services, and 2 percent of service delivered in private psychiatrists' offices. Additionally, the suicide rate among the elderly in general is 50 percent higher than that of the young. Restrictions in the Medicare and Medicaid programs have prevented many of these individuals from seeking and receiving sufficient mental health services.

Congress established Medicare at a time when institutionalization was the major form of treatment for the mentally ill. The progress that has been made toward providing alternatives to institutionalization over the past 20 years coupled with breakthroughs in the treatment of mental disorders has changed our understanding of the causes of these illnesses. Proper treatment of mental health problems for the elderly has been severely limited because of the "dark ages" approach we have allowed Medicare to take toward mental health.

As will be discussed here this morning, among the inadequacies that contribute to the poor mental health services provided to nursing home residents are a shortage of trained mental health professionals, overmedication and adverse drug reactions, the failure of Medicaid and Medicare to provide adequate reimbursement for the elderly mentally ill, and the growing number of elderly in this nation which contributes to the growing number of nursing home residents.

The Subcommittee on Human Services has been actively involved for many years in finding ways in which to improve the quality of life for family members and victims of mental illness, in particular Alzheimer's disease and related disorders. The Older Americans Act, as the key vehicle that provides social and human services for the elderly, mandates that area agencies on aging, as part of their coordinating responsibilities for special populations, coordinate community-based long term care services for older persons residing in nursing homes who could return to their homes with the appropriate services. In addition, I am proud that in my capacity as a Member of the Ways and Means Committee, legislation I authored was added to the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) which alleviated the discriminatory Medicare limits on mental health care. My bill increased the maximum Medicare payment for mental health services to $450 in 1988 and $1,100 in 1989.

I have also cosponsored Congressman William Coyne's bill which will permit Medicare to provide direct reimbursement of services provided by psychologists to the elderly mentally ill. This provision with some modifictions has been included in the Ways and Means Reconciliation bill.

We have before us a most distinguished group of witnesses who bring with them a great deal of experience and ideas. It is imperative that we work together to ensure that the mental health needs of elderly nursing home residents are met.

Mr. ROYBAL. Thank you, Mr. Downey.
The Chair recognizes Ms. Snowe.

OPENING STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Ms. SNOWE. Thank you, Mr. Chairman.

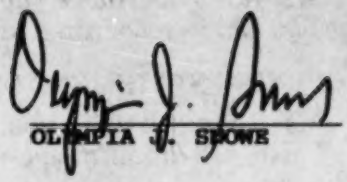
I will ask unanimous consent to include my entire statement in the record.

I want to commend you, Mr. Chairman, for holding these hearings today. I am pleased to be able to join in exploring the problems of providing mental health services to nursing home residents. A significant number of the Nation's elderly and mentally ill need nursing home care. But who is going to provide mental health services and who's going to pay for it? Obviously, these are the kinds of issues that we need to explore today.

When we look towards the future, we recognize that this problem will become even more acute as the nursing home population doubles and triples over the next decade. And the solutions to these problems are going to be difficult and obviously complex. Therefore, I am pleased to welcome our witnesses here today who have the expertise to analyze and assess the problem and provide some recommendations to the committee and ultimately to the Congress.

Thank you, Mr. Chairman.

[The prepared statement of Representative Snowe follows:]



OLYMPIA J. SNOWE

STATEMENT BEFORE THE HOUSE SELECT COMMITTEE ON AGING AND THE SUBCOMMITTEE ON HUMAN SERVICES HEARING ON MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS

August 3, 1989

MR. CHAIRMAN. I am pleased to be here today to join in exploring the problems of providing mental health services to nursing home residents. A significant number of the nation's elderly are mentally ill and need nursing home care. But who is going to provide the services they need? And who is going to pay for it?

This problem will become even more acute as the nursing home population doubles and triples in the coming decades. Nursing home staff typically do not have the training to recognize and intervene in behavior problems. Medicare and Medicaid reimbursement policies severely limit mental health services to the elderly. And the lack of geriatric training

for mental health and other professionals is well documented.

All too often, nursing home residents with behavior problems are conveniently overmedicated with psychotropic drugs. This is shocking as dangerous physical side effects often occur. These drugs may also cause serious psychological effects such as depression, agitation, sedation and confusion. Better ways must be found to manage the mental problems of the elderly in nursing homes.

The solutions to this problem are not simple. Medicare and Medicaid reimbursement and regulation reforms will help. Additional research is needed to understand the extent and types of mental health problems of nursing home residents. More information is needed on effective models of mental health treatment for the elderly in nursing home. And health care professionals need better training for working with nursing home residents with mental problems.

Today's expert witnesses are all actively involved in assessing and analyzing this problem in more detail. They also have important recommendations for our consideration. The nation's nursing home residents deserve quality mental health care as well as quality medical care. Therefore, I look forward to the comments of our witnesses.

Mr. ROYBAL. Thank you.
The Chair now recognizes Mr. Bilbray.

STATEMENT OF REPRESENTATIVE JAMES H. BILBRAY

Mr. BILBRAY. Yes, Mr. Chairman, I appreciate the opportunity for these hearings.

I am not going to be able to remain for the entire hearing because of a delegation meeting we're having that is very important to our State. But I do have a series of questions that I would like to leave with the chairman that could be addressed and/or answered in writing in the future because I believe this is one of the most critical areas of care for the elderly because it's one that's certainly been neglected in most cases.

I thank the chairman for having these hearings.

[The prepared statement of Representative Bilbray follows:]

OPENING STATEMENT OF THE HONORABLE JAMES H. BILBRAY BEFORE THE HOUSE SELECT COMMITTEE ON AGING HEARING ON "MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS", AUGUST 3, 1989

Mr. Chairman, I commend you for calling this much needed hearing on the quality of mental health care that our seniors in nursing homes are receiving. The National Institute of Mental Health has predicted that over 50% of the elderly patients in nursing homes are afflicted by mental illness, and with the nursing home population predicted to triple by 2030, this is certainly not a problem that is going to go away.

Part of the reason that elderly nursing home patients are not receiving adequate mental health care is due to the fact that nursing home personnel are often not trained to care for mentally ill patients, and they frequently are criticized for overmedicating patients with anti-psychotic drugs. In addition, current Medicare and Medicaid reimbursement policies for mental health care are frequently criticized as being inadequate, and I am confident that we will hear some meritorious suggestions today for improving the current policies. Specifically, the Medicaid provision that allows a nursing home to lose its eligibility for Medicaid reimbursement if more than 50% of its patients have primary diagnoses of mental illness has come under particular scrutiny, and I look forward to hearing suggestions on how to reform that provision.

Mr. Chairman, being confined to a nursing home, along with developing the many physical infirmities that are associated with the aging process, is certainly a very traumatic experience for most elderly persons. Recognizing this, we must make every effort to provide humane, compassionate and competent mental health services for our nation's seniors who are patients in nursing homes. I am committed to working with you and my colleagues on the committee to increase the quality of mental health care that our nation's elderly receive, and I look forward to the witnesses' testimony.

Mr. ROYBAL. I thank the gentleman.

Any questions that any Member may have will be submitted to the panel to be answered in writing, we hope, within 10 days. The questions should be more than four or five per Member, and I doubt very much if there will be that many.

But when I said we expected an answer within 10 days, I noticed that the witnesses turned around and looked at one another. I just want to assure you that you're not going to be burdened with a lot of questions, but you will get some. And Mr. Bilbray's questions will be submitted to each and every one of you.

Mr. ROYBAL. The Chair now recognizes Mrs. Morella.

STATEMENT OF REPRESENTATIVE CONSTANCE A. MORELLA

Mrs. MORELLA. Thank you, Mr. Chairman. I appreciate your scheduling this very important meeting, Mr. Chairman, in conjunction with the Subcommittee on Human Services, chaired by Mr. Downey, and Ranking Member, Ms. Snowe.

It's such an important hearing because we're going to be discussing the lack of mental health services for the elderly who reside in nursing homes. It's a multifaceted problem resulting from many factors, such as the lack of trained geriatric mental health professionals, the limited benefits available for mental health services under Medicare, confusion over the jurisdiction of Federal and State governments, to name several of the most important serious problems.

The issue is particularly critical in view of the aging of our population. Mr. Chairman, I look forward to listening to the expertise of our witnesses and to working with members of the committee and with you to develop changes in our current system to ensure the efficient provision of these essential services.

And I thank you, Mr. Chairman.

Mr. ROYBAL. Thank you.

The Chair recognizes Mrs. Unsoeld.

Mrs. UNSOELD. No statement, thank you, Mr. Chairman.

Mr. ROYBAL. Would any other member of the committee wish recognition? Any member who wishes to submit an opening statement for the record may do so.

[The prepared statements of Representatives Oakar, Kennedy, Costello, Saxton and Bentley follow:]

August 3, 1989
Statement of Rep. Mary Rose Oakar
Select Committee on Aging
Subcommittee on Human Services
Hearing on
MENTAL HEALTH IN NURSING HOMES

MR. CHAIRMAN:

I WOULD LIKE TO THANK MY FRIENDS AND DISTINGUISHED COLLEAGUES, CHAIRMAN DOWNEY AND CHAIRMAN ROYBAL AS WELL AS THEIR CAPABLE STAFF FOR MAKING POSSIBLE THIS IMPORTANT HEARING . I CANNOT ADEQUATELY EXPRESS MY SENSE OF THE NEED FOR THIS COMMITTEE TO HIGHLIGHT THE ISSUE ON TODAY'S AGENDA. THEREFORE, I AM ESPECIALLY GRATEFUL TO THE CHAIRMAN FOR THE OPPORTUNITY TO OFFER MY REMARKS ON BEHALF OF THE NEED FOR MORE ADEQUATE MENTAL HEALTH CARE IN OUR NATION'S NURSING HOMES. ADDITIONALLY, I WOULD LIKE TO THANK ALL OF THE DISTINGUISHED PANEL MEMBERS FOR PARTICIPATIN(IN TODAY'S DISCUSSION AS I KNOW THEY RECOGNIZE THE IMPORTANCE OF TODAY'S AGENDA. I WELCOME ALL OF YOUR INFORMED COMMENTS AND VALUABLE INSIGHT.

I AM DEEPLY TROUBLED THAT MENTAL HEALTH CARE IS SO TERRIBLY INACCESSIBLE TO OLDER AMERICANS. APPROXIMATELY 668,000 OLDER AMERICANS IN NURSING HOMES, ABOUT 50-60 PER CENT OF ALL NURSING HOME RESIDENTS IN OUR COUNTRY, HAVE SERIOUS MENTAL DISORDERS. WITH THIS FIGURE IN MIND, I AM CONSIDERABLY DISTRAUGHT TO HEAR THAT GAO REPORTS EVIDENCE OF "SUBSTANTIAL PSYCHIATRIC MISDIAGNOSIS IN NURSING HOMES" IN THE UNITED STATES. IT IS EQUALLY DISTRESSING TO LEARN FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES THAT FEW NURSING HOMES ARE EQUIPPED TO

PROVIDE MENTAL HEALTH SERVICES, AND MOST PROVIDE NONE AT ALL. WITHIN THE NEXT 40 YEARS, GAO EXPECTS THE NUMBER OF NURSING HOME RESIDENTS IN DIRE NEED OF MENTAL CARE TO GROW TO 3.8 MILLION. TO DATE, THE ONLY POSSIBLE SOLUTIONS TO MEET THIS GROWING NEED, ARE THE ONES THAT WE BRING FORTH AS A RESULT OF OUR WORK HERE TODAY.

IN ADDITION TO MY WORK WITH THE SELECT COMMITTEE ON AGING, I AM A MEMBER OF THE BI-PARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, ALSO KNOWN AS THE PEPPER COMMISSION. THERE IS A GIVEN PHILOSOPHY UNDERLYING THE CHARGE OF THAT COMMISSION -- ONE WITH WHICH, I AM SURE, MOST OF THE HEALTH CARE COMMUNITY AGREES. THIS IS, THE IDEA THAT ANY EFFECTIVE CONSIDERATION OF THE HEALTH CARE NEEDS OF OUR CITIZENS, YOUNG AND OLD, MUST ADDRESS PSYCHOLOGICAL NEEDS AS A PART OF THE PACKAGE. WE ARE JUST BEGINNING TO UNDERSTAND HOW CLOSELY OUR PHYSICAL AND PSYCHOLOGICAL NEEDS ARE INTERTWINED.

IMPORTANT STEPS HAVE BEEN TAKEN IN THE 101ST CONGRESS TO MEET THE INCREASING DEMAND AND THE INCREASING COSTS OF MENTAL HEALTH CARE IN OUR NURSING HOMES. I HAVE COSPONSORED CHAIRMAN ROYBAL'S PROPOSAL, THE MENTAL HEALTH AND AGING ACT OF 1989, WHICH WOULD NOT ONLY ADDRESS OLDER AMERICANS' NEED FOR BETTER ACCESS TO MENTAL HEALTH CARE, BUT ALSO THE QUALITY AND CONDITIONS OF THAT CARE. FOR MY PART, I HAVE INTRODUCED A BILL (H.R. 208) TO ENABLE MEDICARE TO OFFER "RELATIVELY FRAIL" MEDICARE

BENEFICIARIES A PACKAGE OF COMPREHENSIVE CARE BENEFITS WHICH ENHANCE CURRENT LEVELS OF MEDICARE BENEFITS. THIS PACKAGE INCLUDES COMMUNITY BASED MENTAL HEALTH CARE SERVICES AND WOULD EXTEND COMPLETE MENTAL HEALTH CARE COVERAGE TO MEDICARE BENEFICIARIES IN NURSING HOMES.

THIS COMMITTEE HAS HEARD TESTIMONY IN THE PAST TO THE EFFECT THAT WITHIN ONE YEAR OF ENTERING A NURSING HOME, OVER 90 PERCENT OF THESE ELDERLY ARE IMPOVERISHED. ONE GREAT MEASURE OF A CIVILIZED SOCIETY IS THE EXTENT TO WHICH IT RESPECTS AND CARES FOR THE NEEDS OF ITS ELDERLY. WE MAY ALL DISAGREE ON THE MEANS TO THIS END, BUT WE SHOULD NOT DISAGREE THAT AS THE MOST POWERFUL NATION IN THE FREE WORLD, WE ARE FALLING MISERABLY SHORT.

IT IS MY HOPE THAT THIS HEARING MAY SHED SOME NEW LIGHT ON THE MENTAL HEALTH CARE CRISIS FACING OUR NURSING HOMES, IN ADDITION TO BRINGING ABOUT A RENEWED PUBLIC AWARENESS OF THE PROBLEMS THAT WE ALL MUST FACE.

I EAGERLY AWAIT THE COMMENTS AND SUGGESTIONS OF MY COLLEAGUES AND THE EXPERT PANEL ASSEMBLED HERE, AND AGAIN, I THANK THE CHAIRMAN FOR ALLOWING ME THE OPPORTUNITY TO OFFER MY REMARKS.

JOSEPH P. KENNEDY II
9TH DISTRICT, MASSACHUSETTS

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House of Representatives
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CONGRESSMAN JOSEPH P. KENNEDY II
OPENING STATEMENT
SELECT COMMITTEE ON AGING
"MENTAL HEALTH IN THE NURSING HOMES"
AUGUST 3, 1989

First of all let me thank all the witnesses for taking the time out of their schedules to come here and talk about one of the most disturbing trends seen in America today and that it is, the increasing prevalence of mental health problems in the elderly population, particularly in those elderly who reside in nursing homes. I was reading just the other week in the New York Times about the alarming increase in elderly suicides -- a 26% increase over the past 6 years -- which puts elderly suicides almost two times ahead of the national average.

I think this fact alone is reason for us to start thinking about how we can make mental health care services more accessible to the elderly whether they reside in a nursing home or in their own homes. And whether this means providing direct reimbursement for other providers such as nurses and social workers so that they can seek out and provide services to the elderly who are depressed and the most vulnerable, then this is what needs to be done. I'll be interested in hearing from our distinguished panel about some of their solutions to address this most disturbing problem.

OPENING STATEMENT
BY U.S. RER. JERRY COSTELLO
SELECT COMMITTEE ON AGING
AUGUST 3, 1989
"MENTAL HEALTH IN NURSING HOMES"

Mr. Chairman, there is a growing lack of mental health services for nursing home patients, and a great majority of them are elderly Americans.

As the Select Committee has revealed, current research demonstrates that almost one quarter of elderly Americans suffer from significant mental health problems, and do not receive adequate mental health care in long-term care facilities.

There is a lack of qualified professionals in these nursing homes, and their elderly patients are often victims of helplessness and neglect.

Today's hearing will examine this lack of mental health care for many elderly nursing home patients, and hear from our witnesses on ways that this care might be improved to offer a range of additional mental health care services to older Americans.

In addition, the committee will consider the ways in which Medicare and Medicaid funding can be used as ways to promote more efficient and effective care for the mentally ill. We have seen how these programs have led to a lack of mental health care for many seniors, and there must be initiatives aimed at improving the use of these funds for the care of older Americans.

STATEMENT OF CONGRESSMAN SAXTON
HOUSE SELECT COMMITTEE ON AGING JOINT HEARING

"Mental Health in Nursing Homes: Barriers and Solutions"
August 3, 1989

I WELCOME THE OPPORTUNITY TO JOIN WITH MY COLLEAGUES ON THE AGING COMMITTEE AND THE SUBCOMMITTEE ON HUMAN SERVICES TO EXAMINE THE INADEQUACY OF MENTAL HEALTH SERVICES FOR OLDER AMERICANS RESIDING IN NURSING HOMES.

MR. CHAIRMAN, RECENT DATA DEMONSTRATES THAT BETWEEN 15 AND 25 PERCENT OF OLDER AMERICANS ARE SUFFERING FROM SIGNIFICANT MENTAL ILLNESS. DUE TO THE AGING OF OUR POPULATION, THIS NUMBER IS EXPECTED TO DRAMATICALLY RISE. WHILE OUR NURSING HOMES ARE EQUIPPED TO DEAL WITH PHYSICAL DEGENERATION, THEY ARE ILL EQUIPPED TO DEAL WITH MENTAL DISORDERS, DESPITE THE NUMBER OF PERSONS SUFFERING FROM THEM.

ACCORDING TO THE NATIONAL INSTITUTE OF MENTAL HEALTH, THERE ARE OVER 896,000 NURSING HOME RESIDENTS DIAGNOSED AS HAVING A MENTAL DISORDER. THIS IS 64% OF THE NURSING HOME POPULATION. IN FACT, NURSING HOMES HAVE BECOME THE LARGEST SINGLE SETTING FOR THE CARE OF PERSONS WITH MENTAL ILLNESS. YET I AM SURE THAT I AM NOT ALONE IN SAYING THAT I OFTEN HEAR NIGHTMARIC STORIES OF THE OVERMEDICATING OF NURSING HOME RESIDENTS, MANY WHO HAVE MENTAL DISORDERS. MANY OTHERS SUFFER SILENTLY FROM UNTREATED MENTAL ILLNESS. DESPITE THE PREVALANCE OF MENTAL ILLNESS IN NURSING HOMES, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOUND

THAT MOST NURSING HOMES PROVIDE LITTLE OR NO MENTAL HEALTH SERVICES.

ACCORDING TO THE GENERAL ACCOUNTING OFFICE (GAO), THESE INDIVIDUALS ARE (1) THE OLDER, CHRONIC MENTALLY ILL WHO HAVE OFTEN RESIDED IN STATE MENTAL INSTITUTIONS, (2) THOSE WHO ENTERED THE NURSING HOME AS A RESULT OF THEIR MENTAL DISORDER, AND (3) THOSE WHO DEVELOPED MENTAL ILLNESS WHILE RESIDING IN THE NURSING HOME. UNFORTUNATELY, MANY OF THESE INDIVIDUALS SPEND THE REST OF THEIR LIVES SUFFERING FROM THE DEPENDENCE, CONFUSION, AND PAIN OF UNTREATED MENTAL ILLNESS.

I AM SURE THAT MY COLLEAGUES HERE TODAY AGREE WITH ME THAT ESSENTIAL TO EFFECTIVE, HIGH QUALITY HEALTH CARE IS A TEAM OF WELL-TRAINED HEALTH CARE PROFESSIONALS SPECIALIZING IN GERIATRICS. NEEDLESS TO SAY THIS APPLIES TO MENTAL HEALTH PROFESSIONALS, BE THEY PSYCHIATRISTS, PSYCHOLOGISTS, SOCIAL WORKERS, PHYSICIANS AND NURSES. UNFORTUNATELY, ONLY A SMALL PROPORTION OF THESE PRACTITIONERS ARE TRAINED TO WORK WITH THE ELDERLY.

I LOOK FORWARD TO HEARING FROM THE WITNESSES BEFORE US TODAY OUTLINING PROBLEMS AND WORKING WITH US TO REACH SOLUTIONS TO ADDRESS THIS SERIOUS PROBLEM. MAINTAINING THE HIGHEST LEVEL OF INDIVIDUAL PHYSICAL AND MENTAL SOUNDNESS IS VITAL IN ASSURING THE HIGH QUALITY OF CARE WE ALL VALUE AND HAVE COME TO EXPECT, FOR OURSELVES, OUR FAMILY MEMBERS, AND FOR OUR FRIENDS.

Helen Delich Bentley

STATEMENT BY THE HONORABLE HELEN DELICH BENTLEY
FOR THE
JOINT HEARING OF THE HOUSE SELECT COMMITTEE ON AGING
ON
MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS

August 3, 1989

I want to thank the Chairmen for calling this hearing on a matter that is becoming inceasingly more disturbing each year.

The need to address the mental health situation of our ever-increasing elderly population makes me particularly appreciative of our fine witnesses with us here today at this hearing.

At a time when issues of the elderly are so much more in the forefront than ever before, we must pay special attention to the type of mental health care available to our elderly, its quality, and its method of financing.

Existing nursing home health care is purported to be operating, in many cases, on a shoestring and a prayer. This has caused mental health care in these facilities to being relegated to backburner status to the point where it is not functioning at an acceptable level. Often, it is ignored altogether. Additionally, deinstitutionalization has compounded the problem even more.

This, combined with the fact that incentives to avoid mentally-ill aged patients are inherent in the financing and reimbursement system, leave us with a big black hole in our treatment for our elderly mentally ill.

We are long overdue in adequately addressing this problem but hopefully, today we will put ourselves on the path to a responsive, responsible, fiscally-achievable solution to the mental health situation with regard to nursing home residents.

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Mr. ROYBAL. Now we're waiting anxiously to hear from the experts in the field and the distinguished panel we have before us: Dr. Michael Smyer, a clinical psychologist and Dean for Research and Graduate Studies, and College of Health and Human Development at Pennsylvania State University. We also have Dr. Beverly Baldwin, an Associate Professor and Coordinator and Graduate Major in Gerontological Nursing in the School of Nursing at the University of Maryland.

Dr. Barry Fogel, who is the Chairman of the American Psychiatric Association, Corresponding Task Force on Geriatric Psychiatry. Willard Mays, who is the Director of the Older Adult Service Department of Mental Health Office from the State of Indiana. John H. Hogan is the Administrator of the Benedictine Nursing Center in Mount Angel, Oregon. So you see, we have people coming from all over the country. We also have Janet Pacatte, the Aging Services Specialist and Staff Ombudsman for Tarrant County, Texas. Texas had to be represented in this distinguished panel.

First, we are proud to have been able to ask you to come to Washington to testify. Second, we feel quite fortunate in the fact that you accepted this invitation. Could we start with Ms. Pacatte and then go from my left to my right asking each of the panelists to make an opening statement. Ms. Pacatte, will you please proceed in any manner that you may desire.

STATEMENT OF JANET PACATTE, AGING SERVICES SPECIALIST, MENTAL HEALTH ASSOCIATION OF TARRANT COUNTY, TEXAS; AND STAFF OMBUDSMAN FOR TARRANT COUNTY

Ms. PACATTE. Mr. Chairman, members of the committee, my name is Janet Pacatte and I am the Aging Services Specialist at the Mental Health Association of Tarrant County in Fort Worth, Texas. My position also includes acting as the Staff Ombudsman for Tarrant County, a position created as a result of the Older Americans Act ombudsman program. In the role of Staff Ombudsman, I recruit and train volunteer Ombudsmen to act as advocates for over 7,000 nursing home residents of our county. Without the services of a trained volunteer ombudsman, there is no objective representative to act on behalf of our most frail and vulnerable older adults.

In the past 10 years, I have also been involved with advocacy, public education, family support, and public awareness for Alzheimer's disease, and I have learned firsthand about placing a family member in a nursing home. I have served on the National Alzheimer's Association Board of Directors and am presently on the Texas Council on Alzheimer's Disease and related disorders. I am completing my Master's degree in Gerontology from the University of North Texas.

Thus, I come before you today as an advocate for the elderly, as a mental health professional, and as a family member whose mother was in a long-term care facility for 8½ years.

My testimony today is presented on behalf of the National Mental Health Association, which is the largest private, voluntary citizen advocacy organization concerned about treatment and reha-

bilitation for persons with mental illness, prevention, and mental health promotion.

I have three messages for you and your colleagues today: There is a substantial unmet need for mental health services for the nursing home population; there is a substantial unmet need for trained nursing home staff to care and to cope for mentally disordered geriatric patients; and there is a substantial unmet need for funding mental health services in our nursing homes.

National MHA also believes that Federal policies are contributing to this problem, and recommends changes to Medicaid law so as to eliminate current disincentives for nursing homes to provide appropriate mental health care.

Today there are almost a million and a half Americans living in nursing homes. This population more than outnumbers the combined total of individuals in general medical, surgical and psychiatric hospitals. According to HHS, we can expect 2.1 million nursing home residents by the year 2003.

Just to keep up with this explosive number of people, a new 85-bed facility will have to be built each day for the next 14 years. Although substantial numbers of nursing home residents suffer from mental illness and psychiatric disorders, little attention has been paid to mental illness in the nursing home population.

Rates of psychiatric disorders in nursing homes have been estimated to be at least 50 to 94 percent of the population, depending on the method of assessment used. According to one study, between 60 and 90 percent of institutionalized elderly persons have been found to be in need of mental health consultation.

Recently, a 58-year-old woman in one of our county's nursing homes was diagnosed as suffering from severe depression by a psychiatric geriatric nurse. This resident was determined to need psychiatric care and possibly hospitalization because of the following symptoms: she was suspicious of others, did not eat or sleep well, would not talk to others, would not come out of her room, and stayed in her bed all day.

The problem is, how does she receive services? The nursing home is unable to provide this care. She is too young for Medicare and Medicaid will not provide for psychiatric hospital services and will only pay for emergency short-term stays in our county's hospitals.

In additional to the general mental health needs of nursing home residents, there's a large population of individuals who have serious mental illness. As the number of elderly persons in nursing homes has quadrupled over the past 20 years, there has been a corresponding decline in the number of elderly persons who live in long-term psychiatric hospitals.

One study, using geriatric psychiatrists to assess nursing home residents, found 94 percent of nursing home residents have dementia or other mental illness. In addition to psychiatric disorders, this study also assessed the prevalence of behavioral disorders among their sample of nursing home residents.

This data also showed that individuals in nursing homes have a much higher rate of psychiatric disorders than their peers of their same age in the community. A significant number of nursing home admissions are individuals who have serious mental illness, including cognitive impairments. A large proportion of nursing home

residents exhibit behaviors which suggest the need for mental health interventions.

We have a case in Tarrant County of a woman aged 66 who has lived in a nursing home and has displayed signs of mental illness. This woman has frightened other residents, stating that she has a gun. This resident has refused all oral medications, has delusional fears and suspicions, disturbs other residents and other visitors, throws food and drink in the dining room.

This individual is not safe to herself or to other people in the facility. Her prognosis is poor. What does this patient do for mental health services? How does the nursing home staff assist her? And, most importantly, how do other residents in the home live with this disruptive and potentially dangerous resident?

Clearly, there is a significant need for mental health services in our Nation's nursing homes. Equally clearly, to those of us who work in such facilities, these services are rarely available.

New legislation enacted a year ago to screen individuals with mental illness prior to nursing home placement will help ensure that individuals are only placed in a nursing home when they do indeed need nursing home care. This law should reduce the number of people with mental illnesses who have been inappropriately placed in nursing homes, often because of the State's desire to shift fiscal responsibility to Federal funding sources such as Medicaid.

Nonetheless, there will still be significant numbers of mentally ill persons in nursing homes, and in reality many nursing homes are without the trained personnel and treatment approaches to meet their needs.

What the past few decades have taught us, is that in spite of a policy of deinstitutionalization for mentally ill people, we continue to need a long-term residential service for some individuals who have serious mental illness.

Nursing home residents need to have a full spectrum of mental health services available to them, just as you or I would need. They need counseling for depression and adjustment problems, they need socialization, they need accurate psychiatric diagnosis and treatment rendered by trained personnel, they need medication management, and they may need special units within nursing homes.

Very few nursing homes have any of these services. In Tarrant County, nursing homes have access to limited staff from our community mental health center who then provides counseling, medical consultation, and therapies. The center staff gives services to residents who are dangerous and disruptive to other residents.

Another problem that concerns me is that whereas hospitals are required to continue psychiatric treatment for persons that they have started with psychiatric treatment, nursing homes are not. Thus, nursing homes are not required to keep individuals if they find them to be too disruptive to the smooth running of the facility.

Nursing home aides, who give up to 90 percent of the hands-on treatment of a patient, have little educational preparation to understand the complex psychosocial aspects of the individual residents.

In some instances that we are aware of, aides have responded to resident anger, hostility and aggressive behavior with their own ag-

gressive behavior toward the resident, resulting in resident physical or psychological abuse.

Another consequence of the lack of appropriate mental health consultation and mental health treatment is inappropriate use of physical and chemical restraints. The overuse of medication is another common problem for nursing home residents. Residents of nursing homes may be given doses of psychotropic drugs which can be very dangerous, especially for the elderly.

There have been several recent studies concerning misuse of psychotropic drugs as chemical restraints for nursing home residents. The author of one report refers to this practice as the "silent but potent partner in accomplishing the warehousing of human beings."

I cannot begin to share with you the dismay and horror I felt, as a family member, as I went in and saw my own mother in a drug-related stupor, hallucinating and completely out of touch with reality because she was on inappropriate psychotropic drugs.

Appropriate mental health care in nursing homes will require expert psychiatric and other mental health professional consultation and the judicious use of psychotropic drugs.

In addition, nurses and nurses aides need to be trained on how to recognize and manage mental illness in nursing homes. Funding for mental health services has traditionally taken low priority to funding for services for physical disorders. For the nursing home population, mental health funding is very scarce.

National MHA would like to make three proposals to changes to Federal policy. These include: eliminating a current disincentive for nursing homes to provide mental health care; facilitating the use of community mental health programs to help furnish mental health care in nursing homes; and, requiring nursing homes to provide a minimum level of mental health care.

The disincentive for nursing homes to provide mental health care comes from the exclusion under Medicaid of services in an Institution for Mental Diseases. Under Medicaid rules, no facility which is considered to an IMD is eligible for Medicaid reimbursement, unless the States elect to cover individuals over 65 in IMDs in their State plan. Currently, eight States, including Texas, do not have this option, but even in States that do, reimbursement is not available in an IMD for persons under age 65.

Our second proposal is to allow community mental health clinics to bill Medicaid for services in nursing facilities to Medicaid eligible clients. Currently, Medicaid clinics services can only be provided in the clinic setting and not off-site, such as in the nursing homes.

A few years ago, Congress amended Medicaid to allow off-site clinic services to be provided for homeless persons. A similar amendment to permit clinics to provide mental health services in nursing homes would give nursing home operators access to qualified mental health professionals to provide consultation and patient care.

Finally, we recommend that the regulations spelling out the standards nursing homes must meet to receive Medicaid and Medicare money should include a requirement that they provide mental health care services. Such services should include at least crisis

intervention services, individual group and family psychotherapy, prescription and monitoring of medication, training in medication management and other psychiatric rehabilitation services.

In summary, the mental health needs of our Nation's nursing home residents are not adequately addressed. Lack of education for nursing home staff, lack of appropriate mental health professionals trained in geriatrics as well as gerontology, lack of linkages between mental health provider agencies and nursing homes, and lack of funding contribute to warehousing hundreds of thousands of elderly Americans who suffer from a mental illness.

I urge you to take steps to meet the needs I have mentioned today to reinforce the importance of assessing the mental health needs of nursing home residents and to improve the appropriateness of nursing home care for our most frail and vulnerable older adults.

Thank you.

[The prepared statement and supplemental material submitted by Ms. Pacatte follows:]

Statement Of

National Mental Health Association

To

Select Committee on Aging
U.S. House of Representatives

Concerning

Mental Health in Nursing Homes: Barriers and Solutions

Presented By

Janet Pacatte
Aging Services Specialist
Mental Health Association of Tarrant County, Texas
and
Staff Ombudsman for Tarrant County

August 3, 1989

Mr. Chairman, members of the Committee my name is Janet Pacatte and I am the Aging Services Specialist at the Mental Health Association of Tarrant County in Fort Worth, Texas. My position also includes acting as the Staff Ombudsman for Tarrant County, a position created as a result of the Older Americans Act ombudsman program. In the role of Staff Ombudsman, I recruit and train volunteer Ombudsmen to act as advocates for over 7,000 nursing home residents in our county.

In the past ten years I have been involved with advocacy, education, public awareness and family support for Alzheimer's Disease, and I have learned first-hand about placing a family member in a nursing home. I have served on the National Alzheimer's Association Board of Directors and am presently on the Texas Council on Alzheimer's Disease and Related Disorders. I am completing my Master's Degree in Gerontology from the University of North Texas.

Thus, I come before you today as an advocate for the elderly, as a mental health professional, and as a family member whose mother was in a long-term care facility for eight and a half years.

My testimony today is presented on behalf of the National Mental Health Association, which is the largest private, voluntary citizen advocacy organization concerned about treatment and rehabilitation for persons with mental illnesses, prevention, and mental health promotion.

I have three messages for you and your colleagues in Congress today:

- There is a substantial unmet need for mental health services for the nursing home population

- There is a substantial unmet need for trained nursing home staff to cope and care for mentally disordered geriatric patients, and

- There is a substantial unmet need for funding mental health services in nursing homes.

NMHA also believes that federal policies are contributing to this problem, and recommends changes to Medicaid law so as to eliminate current disincentives for nursing homes to provide appropriate mental health care.

THE NEED FOR SERVICES

Today there are almost a million and a half Americans living in nursing homes. This population more than outnumbers the combined total of individuals in general medical, surgical and psychiatric hospitals. Although substantial numbers of nursing home residents suffer from psychiatric disorders, little attention has been paid to mental

illness in the nursing home population.[1] Rates of psychiatric disorders in nursing homes have been estimated to be anywhere from at least half of the population to 94% depending upon the method used to make the assessments. According to one study, between 60 and 90% of institutionalized elderly persons have been found to be in need of mental health consultation. Depression is common in older adults. Nursing home residents facing their own declining health, and that of their friends, separation from their family, the loss of their homes and their self-esteem, often suffer grief, anger, despair, sadness and rage. These people have few emotional, familial or financial resources with which to face these mental health problems, and most nursing homes offer no general mental health services.

Recently, a 58-year old woman in one of our county's nursing homes was diagnosed as suffering from severe depression by a psychiatric geriatric nurse. This resident was determined to need psychiatric care and possibly hospitalization because of the following symptoms: she was suspicious of others, did not eat or sleep well, would not talk to others or come out of her room and stayed in bed most of the day. The problem is, how can she receive services? The nursing home is unable to provide this care, she is too young for Medicare coverage and Medicaid will not pay for psychiatric hospital services and will only pay for emergency short-term care in city or county hospitals.

In my own state of Texas, the Health Department recently cut funds for social workers in nursing homes. These workers were often the only people capable of recognizing and treating general mental health problems in residents.

In addition to the general mental health needs of nursing home residents, there is a large population of individuals who have serious mental illness. As the number of elderly persons in nursing homes quadrupled over the past 20 years, there has been a corresponding decline in the number of elderly persons who live in long-term psychiatric hospitals. At this time, approximately 19% of nursing home residents have a primary diagnosis of mental disorder or senility without psychosis, almost double the rate reported by the National Institute of Mental Health for elderly persons who live in the community.[2]

One study, using geriatric psychiatrists to assess nursing home residents, found 94% of nursing home residents have dementia or other mental illnesses. In addition to psychiatric disorders, this study also assessed the prevalence of behavioral disorders among their sample of nursing home residents. Behavioral problems were prevalent at a high rate: 76% of the residents were found to have at least one maladaptive behavior, and 40% to have five or more behavioral problems.

Among nursing home residents who have a mental illness, almost 90% have been identified as presenting behavior problems as compared with about half of the residents who have physical illnesses. These behavior problems included difficulty in communication, socially objectionable or disruptive behavior, aggressive behavior, wandering, noisiness, demanding behavior and destructiveness.

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These data show that:

- Individuals in nursing homes have much higher rates of psychiatric disorders than do their community peers of the same age;

- A significant portion of nursing home admissions are individuals who have serious mental illnesses, including cognitive impairments;

- A large proportion of nursing home residents exhibit behaviors which suggest the need for mental health interventions.

We have a case in Tarrant County of a woman, age 66, living in a nursing home who displays signs of serious mental illness, and who frightened another resident by threatening to shoot her, stating that she had a gun. This resident was refusing all oral medications, had delusional fears and suspicions, disturbed other visitors, talked to herself and threw food and drink in the dining room. This individual is not safe, to herself or other residents in the facility. Her prognosis is poor. What does this patient do for mental health services? How does the nursing home staff assist her? And, most importantly, how do other residents in the home live with this disruptive and potentially dangerous resident?

Clearly, there is significant need for mental health services in our nation's nursing homes. Equally clearly, to those of us who work with such facilities, these services are rarely available.

New legislation enacted a year ago to screen individuals with mental illness prior to placement in a nursing home will help ensure that individuals are only placed in a nursing home when they do indeed need nursing home care. This law should reduce the number of people with mental illnesses who have been inappropriately placed in nursing homes, often because of the state's desire to shift the fiscal responsibility of providing care for mentally ill individuals to federal funding sources such as Medicaid. Nonetheless, there will still be significant numbers of mentally ill persons in nursing homes, and in reality many nursing homes are without the trained personnel and treatment approaches to meet their needs. What the past few decades have taught us, is that in spite of a policy of deinstitutionalization, we continue to need a long-term residential service for some individuals who have serious mental illnesses.

Nursing home residents need to have a full spectrum of mental health services available to them. They need counseling for depression and adjustment problems, they need socialization, they need accurate psychiatric diagnosis and treatment rendered by trained personnel, they need medication management, they may need special units within nursing homes.

Very few nursing homes have any of these services. In Tarrant County, nursing homes have access to limited staff from the community mental health center who then provide counseling, therapies and medical consultation. The center staff gives services primarily to residents who are dangerous and disruptive to other residents. This

program has been operated by the mental health center for a number of years, but the center has great difficulty in finding the resources to pay for it. Even if the nursing home residents are Medicaid-eligible, no federal funds are available for this service.

Another problem that concerns me is that whereas hospitals are required to continue psychiatric treatment they have started with patients and to follow-up, nursing homes are not.[3] Thus, nursing homes are not required to keep individuals if they find them to be too disruptive to the smooth running of the home.

THE NEED FOR TRAINED STAFF

Nurse aides, who give up to 90% of the hands-on care to a nursing home resident in Texas, do not have the educational preparation to understand the complex psychosocial aspects of the disruptive behavior of certain residents. In some instances that I am aware of in our own community, aides have responded to resident anger, hostility and aggressive behavior with their own aggressive behavior toward the resident, resulting in resident physical or psychological abuse.

Another consequence of the lack of appropriate mental health consultation and mental health treatment is inappropriate use of physical and chemical restraints.

One study I am familiar with reported that when nursing home staff are not able to care effectively for residents with disruptive or violent behavior, the residents are often sent to a nearby hospital. Many of these residents were sent to the hospital because they had struck other residents or staff members, and in some cases the hospital was told that the patient had been discharged from the home, so don't send her back. It is frustrating to know that many incidents like this could be avoided before the patient's symptoms reach crisis level, if the staff in the home were trained in recognizing and treating mental and emotional problems.

I find that many physicians and nurses have been inadequately educated to identify behavioral signs of mental illness. Mental disorders in nursing home residents are frequently undiagnosed, misdiagnosed or diagnosed in a way that obscures disorders.

The overuse of medications is another common problem for nursing home residents. Residents of nursing homes may be given doses of psychotropic medications inappropriately and too often. Medications can be addictive and dangerous, especially with the elderly. There have been several recent studies concerning misuse of psychoactive drugs as chemical restraints for elderly persons in nursing homes. The author of one report refer to this practice as a "silent but potent partner in accomplishing the warehousing of human beings"[4]

Side effects of these medications may include constipation, drowsiness, urinary retention, increase or decrease in sexual drive, hypotension and behavior problems. Residents may also become more confused and agitated if medication is not used appropriately. Overuse and misuse of medications may contribute to hallucinations, anxiety, paranoia-like symptoms and depression. Some residents with senile dementia,

and as memory fails they become less able to care for themselves. When they become frightened and anxious, they express these emotions with depression, anger and paranoia. Mr. K, for example, suffered brain damage from a series of strokes. He recognized his family but could not learn the names of new acquaintances. He was combative when frightened and was taking haloperidol (Haldol) to reduce his anxiety and benztropine mesylate (Cogentin) to combat Haldol's side effects. Unfortunately, his drooling and rigidity were not completely counteracted by Cogentin. Both drugs have anticholinergic properties; when taken together, the effects are additive. This is especially dangerous in the elderly. Although the drying effect of Cogentin was desirable for Mr. K, its other side effects -- constipation, hypotension, urinary retention and increased ocular pressure -- were not.

I cannot begin to share with you the dismay and horror I felt when I visited my mother in a nursing home and found her in a drug-related stupor, hallucinating and completely out of touch with reality.

Appropriate mental health care in nursing homes will require expert psychiatric and other mental health professional consultation (such as is provided in Tarrant County by the community mental health center) and the judicious use of psychotropic medications. In addition, nurses and nurses aids need to be trained on how to recognize and manage mental illness and behavioral problems.

FEDERAL POLICY ISSUES

Funding for mental health services has traditionally taken low priority to funding for services for physical disorders. For the nursing home population, mental health funding is very scarce. Individuals covered by Medicare find themselves with a very limited package of outpatient services (although Congress is moving to remove these limits) and have to pay half of all costs of care (compared to only 20% of the cost of care for physical illnesses).

In Medicaid, there are disincentives for nursing homes to provide appropriate mental health care. Instead, there should be requirements for such care, and encouragement of linkages between community mental health programs and nursing homes.

NMHA would like to make three proposals for changes to federal policy, which we believe will significantly improve the situation I have described. These changes would:

- Eliminate a current dis-incentive for nursing homes to provide mental health care;

- Facilitate the use of community mental health programs to help furnish mental health care in nursing homes, and

- Require nursing homes to provide a minimum level of mental health care.

The dis-incentive for nursing homes to provide mental health care comes from the exclusion under Medicaid of services in an Institution for Mental Diseases (IMDs) Under Medicaid rules, no facility which is considered to be an IMD is eligible for Medicaid reimbursement, unless the states elects to cover individuals over age 65 in IMDs in its state plan. Currently, eight states, including Texas, do not have this option, but even in states that do, reimbursement is not available in an IMD for persons under age 65. Nursing homes, as well as psychiatric hospitals, can be classified as IMDs if they meet the federal definition of an IMD, and if that occurs then the home is ineligible for any Medicaid reimbursement for any individual in that home (except those over age 65 in states with this option). As you can see this is a devastating impact, and as a result, nursing home operators are very nervous about being found to be an IMD.

Unfortunately, the federal guidelines describing IMDs are somewhat subjective and include criteria that have to do with provision of mental health care. NMHA believes that the Health Care Financing Administration (HCFA) should modify its definition of an IMD so as to eliminate criteria which relate to the provision of mental health care, and focus only on criteria which are more appropriate for differentiating a psychiatric institutions from a nursing home. Specifically, NMHA recommends that the following five guidelines be eliminated:

- The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases.
- The facility specializes in providing psychiatric/psychological care and treatment.
- A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders
- Independent Professional Review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.
- Part or all of the facility consists of locked wards.

There are five other guidelines which are appropriate for identifying IMDs, and which should be retained, such as:

- The facility is licensed as a psychiatric facility
- The facility is accredited as a psychiatric facility by the JCAH.
- More than 50 % of the patients have mental diseases, other than dementias.

This change could be made by the Administration, and with relative ease since the policy in question is a guideline, not a formal regulation. NMHA urges the Committee to contact the Administrator of HCFA as soon as he/she is appointed to

urge this change.

Our second proposal is to allow community mental health clinics to bill Medicaid for services in nursing facilities to Medicaid eligible clients. Currently, Medicaid clinic services can only be provided in the clinic facility, and not "off-site", such as in a nursing home. A few years ago, Congress amended Medicaid to allow off-site clinic services to be provided to homeless persons. A similar amendment to permit clinics to provide mental health services in nursing homes would give nursing home operators access to qualified mental health professionals to provide consultation and patient care.

Finally, we recommend that the regulations spelling out the standards nursing homes must meet to receive Medicaid and Medicare funding should include a requirement that they provide mental health care services. Such services should include at least: crisis intervention services, individual, group and family psychotherapy, prescription and monitoring of medication, training in medication management and other psychiatric rehabilitation services.

NMHA urges the Committee to contact HCFA and suggest to the agency the importance of including this requirement in the nursing home conditions of participation when these are revised to reflect the provisions of OBRA (this is to be done by October 1990).

Taken together, these three changes could radically alter the deplorable situation now found in so many nursing homes where staff are untrained, lack professional support and residents go without essential mental health treatment and are often inappropriately restrained.

CONCLUSION

In summary, the mental health needs of our nation's nursing home residents are not being adequately addressed. Lack of education for nursing home staff, lack of appropriate mental health professionals trained in geriatrics, lack of linkage between mental health provider agencies and nursing homes, and lack of funding contribute to warehousing hundreds of thousands of elderly Americans who suffer from a mental illness.

I urge you to take steps to meet the needs I've mentioned today to reinforce the importance of assessing the mental health of nursing home residents and to improve the appropriateness of nursing home care for our most frail and vulnerable older adults.

Please, Mr. Chairman, will you intervene to make some changes in the lives of the people I work with.

QUESTIONS FOR JANET PACATTE, STAFF OMBUDSMAN, TERRANT COUNTY TEXAS; REPRESENTATIVE OF THE NATIONAL MENTAL HEALTH ASSOCIATION

1. One of your recommendations on behalf of the National Mental Health Association is that nursing homes be required to provide a minimum level of health care. What would you say constitutes a minimum level of mental health care in a nursing home?

2. You mention the use of community mental health programs to provide mental health care in nursing homes. Could you give some specifics on how you envision the operation of such a program?

3. You refer several times in your testimony to the overuse of psychotropic medication. What specific actions could be taken to prevent this?

National Mental Health Association™

President
Carol W. Garvin
Aiken, SC
National Executive Director
Preston J. Garrison
Alexandria, VA

August 16, 1989

Select Committee on Aging
House Annex # 1, Room 712
300 New Jersey Avenue, S.E.
Washington, D.C. 20515

Enclosed are the responses to Chairman Roybal's questions to Janet Pacatte, for inclusion in the record on the recent hearing on mental health care in nursing homes.

Since the second of the written questions was asked during the hearing, we are submitting additional information about how the cmhc in Texas provides services to nursing homes, which should be added after the oral comments which Janet made during the actual hearing.

NMHA appreciated the opportunity to participate in this important hearing. I thought the panel of experts was superb and really brought out all the issues clearly, and repeatedly.

Thank you for all your good work on behalf of people with mental illnesses.

Sincerely,

Chris

Chris Koyanagi
Director of Federal Relations

Responses to questions for Janet Pacatte re. Committee hearings on mental health and aging.

1. Mental health care in nursing homes should consist of:

--crisis intervention services
--individual, group and family psychotherapy
--prescription and monitoring of medication
--training in medication management
--other psychiatric rehabilitation services (including: (i) development and maintenance of daily living skills, such as grooming, personal hygiene, nutrition, health and mental health education, money management and maintenance of living environment, (ii) structured socialization activities to diminish tendencies towards isolation and withdrawal, and (iii) development of appropriate personal support networks).

2. *Note: Ms Pacatte partly answered this question during the hearing, the following information should be added to her answer.*

We have a particular community mental health program which has targetted the elderly population in nursing homes for services. This program is funded primarily from state funds, although residents are charged a fee, on a sliding scale basis, if they are able to pay. This mh program has an on-going relationship with local nursing homes. First priority is given to individuals who have been released from a state hospital, and the mental health center is required to provide services to these individuals. In addition, the resident, a family member, the Ombudsman or nursing home staff can request services for a particular resident. The community mental health center staff normally go to the nursing home to treat the patient (since most residents in our nursing homes are old, frail and not ambulatory) but on occasion a resident may go into the clinic for services. The mental health center also provides on-going in-service training for nursing home staff about mental illnesses, and about techniques for handling behavior problem patients.

3. There are three ways in which the appropriate use of psychotropic medications in nursing homes can be dealt with:

1) Through the survey procedure, the Health Care Financing Administration can set standards and guidelines concerning appropriate use of specific medications, which would enable surveyors to identify occasions when psychotropic (and other) medications are being over-prescribed or mis-prescribed. Sanctions can then be imposed if this constitutes violations of federal standards. I understand that HCFA is moving towards implementing such a system, but that there is some resistance to it in some quarters. However, NMHA believes that such a system would greatly protect nursing home residents.

2) Under the OBRA amendments there are now requirements for outside evaluations of the prescription of psychopharmacologic drugs, and this provision should be vigorously enforced.

3) Clear standards should be promulgated by HCFA to implement the resident's right, also described in OBRA, to be free from chemical restraints. No regulations have yet been issued on this provision, but such regulations should as a minimum make clear that these medications cannot be used for purposes of restraint, for the convenience of the staff, or to compensate for the lack of staff in a home.

Finally, I would like to add that education of nursing home staff could greatly aide in reducing the mis-use of these drugs. Nurses aids must be trained in appropriate ways of dealing with difficult patients, so that neither physical nor chemical restraints become necessary. There are nursing homes which never use restraints, so we know it can be done.

Mr. ROYBAL. Thank you very much. The Chair recognizes Dr. Smyer.

STATEMENT OF MICHAEL A. SMYER, PROFESSOR OF HUMAN DEVELOPMENT, PENNSYLVANIA STATE UNIVERSITY

Dr. SMYER. Mr. Chairman, members of the committee, thank you for giving me this opportunity to testify today. My name is Michael Smyer. I am a clinical psychologist by training and a licensed psychologist in the Commonwealth of Pennsylvania. I am currently a Professor of Human Development and Associate Dean for Research and Graduate Studies in the College of Health and Human Development at Penn State.

I am a Fellow of the American Psychological Association and a Fellow of the Gerontological Society of America. And for the last 15 years, I have been involved in the development implementation and evaluation of health and mental health related services for older adults and their families. So I come to you as a clinician and a researcher involved in a program of research focused on one primary setting, and that is nursing homes.

One of the advantages, Mr. Chairman, of going second is that I get to say "amen" to everything my colleague, Ms. Pacatte, said already.

In my written testimony many of the themes she has enumerated I have expanded on, so I will not go over much of the same ground in the interest of time.

However, I would want to emphasize that nursing homes represent the intersection of personal lives, public policy, and geriatric practice. As she pointed out, they are also major receiving sites for mentally ill elderly.

In my comments this morning, though, I want to emphasize three elements: First, as she has pointed out, there is a substantial rate of mental health problems among nursing home residents.

Second, there's a critical need for improved geriatric training in the core mental health disciplines and; third, current barriers to effective mental health treatment exist in both the Medicare and Medicaid programs.

I will highlight the problem of polypharmacy in nursing homes as an example that represents the intersections of these problems in a few moments.

As my colleague pointed out, the problems of nursing home residents are substantial and they are substantial in a variety of ways, both in terms of the demographics of the nursing home population, which is expected to more than triple between now and the year 2040, as well as the cost of nursing home care which currently exceed $40 billion annually, with the Federal Government paying just over 25 percent of that.

More importantly, for this morning's hearing, however, the substantial mental health needs. As pointed out by my colleague earlier, estimates range from more than 50 to as much as 94 percent of nursing home residents have a diagnosable mental disorder and are in need of mental health consultation.

Linked to that are the substantial behavioral problems that are correlates of diagnosed and undiagnosed mental disturbances.

Again, colleagues from Johns Hopkins and elsewhere have documented the range of behavioral disturbances that many nursing home residents display.

From our perspective, however, equally important are the staffing issues involved in nursing home settings at the current time. If you think about nursing home staffs, you can think of them as a pyramid with the base of the pyramid being nursing assistants or nurses aides. That group is the largest group of staff having the most direct contact with older adults in the nursing home setting and they are the least trained and least educated in the setting.

In contrast, the top of the pyramid—the physicians—represent the smallest group with the least contact with the residents. And if we look at the subgroup of physicians, that is, psychiatrists, who should have the best training in geriatric mental health issues, they are even rarer in terms of their access and active involvement in the setting.

A recent commentary by a group of psychiatrists on the state of affairs, reported that "fewer than 1 percent of all patients with a diagnosable mental disorder received explicit mental health intervention. Nationwide psychiatric consultation appears to be requested rarely, even when behavioral problems are serious."

In terms of availability we know that there's a current shortage of well trained geriatric practitioners and academic specialists in geriatric mental health in all of the four core mental health disciplines, and those include psychiatry, psychology, social work, and geriatric nursing. There are estimates that by the year 2000 we will need as many as 65,000 practitioners and academic faculty members to train and provide services for older adults in need of mental health consultation. At the current time, however, we are far short from reaching those numbers.

In addition to a lack of adequate staff, we also have barriers to the provision of care even when geriatric mental health expertise is available.

In my testimony I provide an example of a colleague in Colorado who is extremely well trained, both at the doctoral and post-doctoral level in geriatric mental health care. As a psychologist she is constrained by Medicare regulations in terms of reimbursement as an independent practitioner and has had a great deal of difficulty providing care both on an outpatient basis and in nursing homes despite her geriatric expertise.

However, in this morning's comments I want to focus on one particular area that Ms. Pacatte alluded to earlier and that is the problem of drug use in nursing homes, because from my perspective, drug use represents an intersection of problems with staffing and disincentives to involving appropriate mental health staff in nursing homes.

A recent report by the Inspector General of the Department of Health and Human Services summarized information on the use of prescription medicines in nursing homes, and I quote:

"Sixty-one percent of the institutionalized elderly receive three or more different prescription drugs in a year, 37 percent receive five or more, and 19 percent receive seven or more."

At first glance this may seem like appropriate treatment given the mixture of physical and mental health problems that nursing

home residents have. However, a variety of studies over the last decade have documented the rate of inappropriate medication regimens in nursing homes.

Wayne Ray and his colleagues at Vanderbilt a decade ago suggested that 43 percent of the Medicaid recipients in nursing homes received antipsychotic drugs, a rate much beyond what one would expect.

Similarly, a more recent survey by Burns and Kamerow found that 33 percent of their sample received antipsychotic drugs, and 21 percent of those receiving such drugs had no diagnosable mental disorder.

The effects of these medications was powerfully conveyed in a recent editorial by Hal Willard, a journalism professor, writing about his 94-year-old mother. He said:

"No matter how old you are, the first time your mother looks at you with blank eyes and speaks gibberish you are going to be shocked. She had been in nursing homes for a few years because of what was variously described as arteriosclerosis, hardening of the arteries, senility, and mistakenly, I think, Alzheimer's disease.

The first shock came the day I walked into her room and found her in the chair, seemingly dozing. I put my hand on her arm and spoke to her softly. When she didn't respond, I spoke louder and shook her gently. Finally, she stirred and opened her eyes. I will never forget the expression in her eyes. She was looking at me from some place I hope never to go."

He goes on to document the range of treatment that she had received in that nursing home, and finally she was transferred to another nursing home. In the meantime, though, he realized that she was being given something called "Mellaril." As he puts it, "I asked the pharmacist what it was and was told that it was a tranquilizer. I didn't know that it was what doctors call an antipsychotic substance and it was a powerful tranquilizer administered to keep patients quiet.

"I found out the truth about the drugs by accident. I transferred mother to another institution and in her new home mother began to improve within a short time and in a few weeks she was her old vibrant self.

"I asked the nurses and her new doctor the cause of the remarkable improvement. They said they had merely stopped giving mother Mellaril. She didn't need it."

Mark Beers, an internist, in recent congressional testimony, summarized the implications of this pattern of overmedication and he said: "It is likely that the widespread overuse and misuse of psychoactive medications add to the psychological woes of nursing home residents.

First, when used inappropriately, they may cause depression, agitation, sedation, and confusion.

Second, they may mask psychological disease and make depression, anxiety and confusion difficult to recognize. As long as these medications are overused, the impact of increased nonpharmacological mental health services may be lessened."

Similarly, Florence Huey, the editor of "Geriatric Nursing", recently pointed out the intersection of nursing shortages and drug treatment in nursing homes. She said:

"When you are the only nurse for 60 or more patients, and each of your aides has an assignment of 15 residents, how much time will you find to 'talk down' an elderly resident who is striking out at staff and other residents?

"Even if your years of experience with many newly admitted elders who become aggressive when they were depressed and grieving over their lost lifestyle warn you that an elder's belligerence may reflect fear, not psychosis, chances are you're overwhelmed."

In short, the intersection of lack of trained personnel and disincentives for those who are trained to practice in this setting, contribute to the overmedication and inappropriate medication of nursing home residents.

In my comments I go on to talk about the role of research. As an Associate Dean for Research, research is an item that I feel compelled to mention. But it is clear that we need a more aggressive approach to cost-effective, nonpharmacological treatment approaches in the setting.

In closing, Mr. Chairman, I want to focus on three specific elements in my recommendations:

The availability of service providers with geriatric mental health expertise; providing access to those service providers; and encouraging demonstration projects and research on cost-effective approaches to treating the mental disorders of nursing home residents.

First, in terms of availability. Funds should be earmarked for preparation of academic and clinical geriatric practitioners in the four core mental health disciplines of psychiatry, psychology, social work, and nursing.

Second, in terms of access, recently proposed Medicare reconciliation provisions should be supported, since they increase older adults' access to clinical psychologists and clinical social workers. These provisions allow clinical psychologists and clinical social workers to be reimbursed by Medicare for mental health services, if the services would be paid for if furnished by a physician and if the clinician is licensed in the State to furnish such services.

In a related area, H.R. 1649, which provides for increased salaries for nursing home staff with the costs passed through to the Medicaid program, should be supported. This measure will enable long-term care settings to attract the qualified nursing staff necessary to appropriately provide the complicated pharmacological and other treatment regimens that nursing home residents need.

Finally, the Health Care Financing Administration should be directed to carry out demonstration projects assessing the cost-effectiveness and impact of several different service approaches: projects focusing on pharmacists-as-prescriber and projects focusing on the role of nursing staff in the area of polypharmacy; projects focusing on the effects of training and other techniques to improve the functioning of nursing assistants as mental health as well as physical health care providers; projects assessing the impact of the 1987 OBRA training and preadmission screening provisions on quality of care and mental health treatment for older adults who have both mental and physical health problems.

Nursing homes are both mental and physical health treatment settings. Epidemiological data clearly document that the majority of nursing home residents have a mental disorder.

Additional data suggest that there are few geriatric mental health practitioners currently working in this setting. One result is that psychotropic medications are used more frequently than is appropriate. A variety of strategies are needed to make the settings more effective.

As Barbara Burns and her colleagues summarized, the next steps are the following: "enlightened reimbursement policies, innovative approaches to providing mental health service in nursing homes, improved training for caregivers, and more research on this topic is imperative."

Thank you, Mr. Chairman.

Mr. ROYBAL. Thank you, Dr. Smyer

[The prepared statement and supplemental material submitted by Dr. Smyer follows:]

TESTIMONY OF

MICHAEL A. SMYER, PH.D.
PROFESSOR OF HUMAN DEVELOPMENT
PENNSYLVANIA STATE UNIVERSITY

BEFORE THE

UNITED STATES HOUSE SELECT COMMITTEE ON AGING

ON THE SUBJECT OF

MENTAL HEALTH IN NURSING HOMES

AUGUST 3, 1989

Michael A. Smyer

Introduction

Mr. Chairman, thank you for giving me the opportunity to testify today. My name is Michael Smyer. I am a clinical psychologist by training and a licensed psychologist in the Commonwealth of Pennsylvania. I am currently a Professor of Human Development and Associate Dean for Research and Graduate Studies in the College of Health and Human Development at Pennsylvania State University.

I am a fellow of the American Psychological Association and a fellow of the Gerontological Society of America. For the last fifteen years, I have been involved in research, education,and program development in the area of aging and mental health. During this time, I have been a founding board member of a 92-bed free-standing inpatient mental health facility, the Meadows Psychiatric Clinic in Centre Hall, Pennsylvania, and a founding board member of a continuing care retirement community that will serve 200 older adults, Foxdale Village in State College, Pennsylvania. In addition, I have pursued a program of research focusing on the mental health needs of one particular setting: nursing homes (see Smyer, Cohn, & Brannon, 1988).

Nursing homes are settings that represent the intersection of personal lives, public policy, and geriatric practice. They are also major receiving sites and treatment settings for mentally ill elderly (Harper & Lebowitz, 1986). However, the setting is designed and staffed primarily for physical health care rather than mental health care. Public policy initiatives have significantly contributed to this confusing blend of mission, clientele, and resources (Smyer, in press).

In my comments this morning, I want to emphasize three elements: 1) There is a substantial rate of mental health problems among nursing home residents; 2) there is a critical need for improved geriatric training in the core mental health disciplines; and 3) current barriers to effective mental health treatment exist in the Medicare and Medicaid programs.

Mental Disorders in Nursing Homes

I have been asked to provide a context for much of this morning's discussion. As a starting point, let's consider some basic facts about nursing homes in our society:

> At any one point in time, roughly 5% of the elderly are in nursing homes (Liang & Tu, 1986; Palmore, 1976).

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> An individual's lifetime chance of spending time in an institutional setting is roughly one in five (Palmore, 1976).

> The risk of institutionalization increases with advancing age. In a recent national study, 1% of those aged 65-74 were institutionalized, whereas 22% of those 85+ were in institutional settings (Hing,1987).

> The number of nursing home residents will triple from approximately 1.4 million to more than 4.6 million by the year 2040 (U.S. Senate,1987). (See Figure 1.)

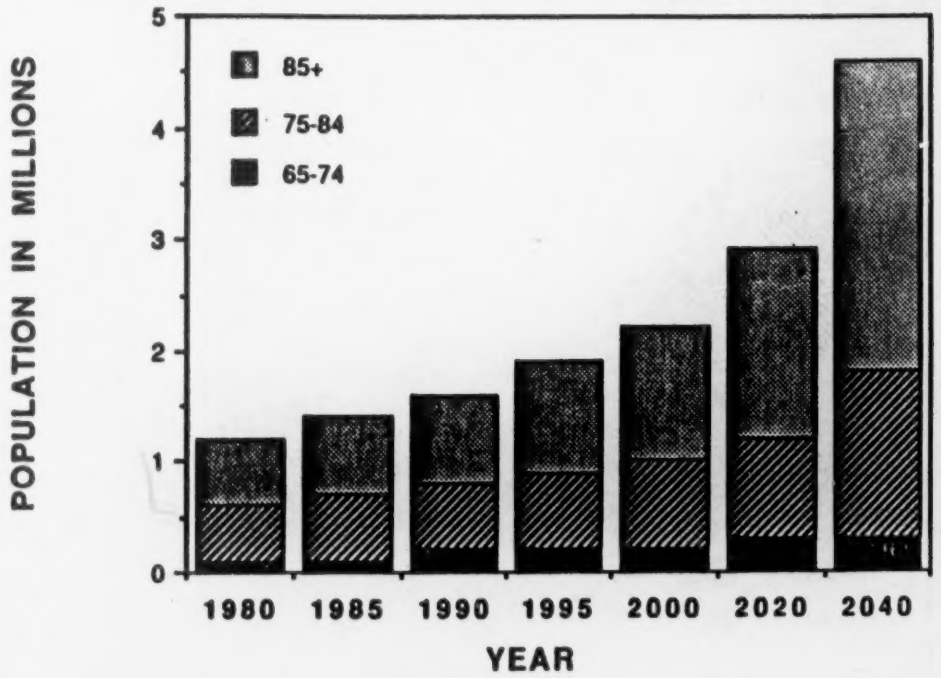
> Current costs of nursing home care exceed $40 billion annually, with the federal government paying just over 25%.

These projections take on added significance as we consider the rates of mental disorders among nursing home residents. Several studies have documented high rates of mental disorders among nursing home residents (e.g., Burns et al., 1988; Goldman, Feder, & Scanlon, 1986). I want to focus on a few studies because they epitomize different strategies for answering two simple questions: 1) What is the prevalence of mental disorders among nursing home residents? and 2) What types of mental health and behavioral problems do nursing home residents have?

The first, carried out by Pearl German and her colleagues at Johns Hopkins University, (German, Shapiro, & Kramer,1986) used the methodology of NIMH's epidemiological catchment area study. Using a standardized research interview and trained interviewers, they reported that as much as 50% of the residents in nursing homes have either a diagnosable mental disorder or cognitive impairment. (See Figure 2). Equally important, they documented that mental health problems are not solely prevalent among those recently admitted to the nursing home. A similar pattern emerged in a study by Burns and her colleagues (Burns et al, 1988). In a national sample of 526 nursing home patients in 112 homes in four metropolitan areas, they found the overall prevalence of mental disorders to be 68%; 39% of the residents had a diagnosis of organic brain syndrome (dementia of some sort); 29% had other mental disorders; and only 31% of the residents had no mental disorder.

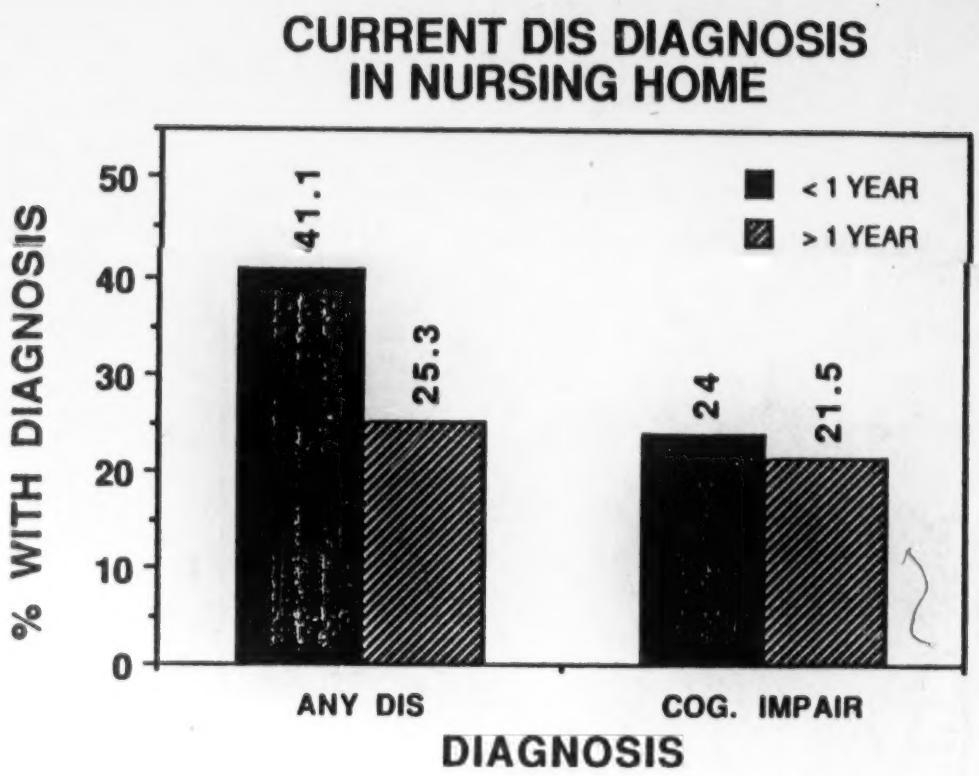
A complementary study by Dr. Barry Rovner and his colleagues (Rovner et al., 1986) used a different methodology: they interviewed a random sample of nursing home residents and used geriatric psychiatrists to make

NURSING HOME POPULATION PROJECTIONS



SOURCE: U.S. Senate (1987).

Figure 1



SOURCE: German, Shapiro, & Kramer (1986).

Figure 2

DSM-III diagnoses. They found that 94% of the residents had a psychiatric disorder. In a related study, German, Rovner, and their colleagues are currently conducting a longitudinal study of mental disorders among nursing home residents. Their preliminary results document high levels of mental disorders: 60% of the residents had a dementia, and of those roughly 20% had an additional mental disorder complicating their treatment picture (Rovner, 1989).

This rate of mental distress among nursing home residents has clear implications for care because of the variety of behavioral correlates of mental distress. (See Table 1).

Staffing Issues

The staffing patterns of nursing homes summarize the resources available for the diagnosis and treatment of mental disorders. (See Figure 3). The majority of care is provided by the least skilled portion of the staff--nursing assistants. Notably, physicians represent the smallest portion of either full-time or part-time staff. When consultation services are considered, the picture remains the same. For example, Borson and his colleagues recently commented on the role of psychiatrists in nursing homes (Borson, Liptzin, Nininger, & Rabins, 1987):

> No reliable data have been published concerning the availability of psychiatric care as a health service to patients in nursing homes. but results of small surveys ...suggest that fewer than 1% of all patients with a diagnosable mental disorder receive explicit mental health interventions. Nationwide psychiatric consultation appears to be requested rarely, even when behavioral problems are serious. (p. 1415).

Their commentary on the involvement of psychiatry could also extend to the other "core" mental health disciplines (psychology, nursing, and social work).

There are several barriers to greater involvement of mental health professionals in nursing homes: availability of professionals trained in geriatrics; financing of services; and models of professional collaboration and cooperation.

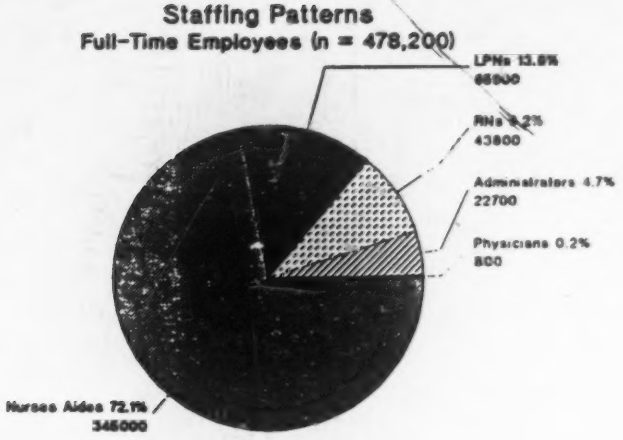
In terms of availability, a report prepared by the Department of Health and Human Services (1987) summarized the estimated number of mental health practitioners needed to serve the elderly. (See Table 2.) At the current time, we are not close to providing the number of needed academics or practitioners.

Prevalence of Behavior Problems in a Random Sample (n = 50) of Nursing Home Residents

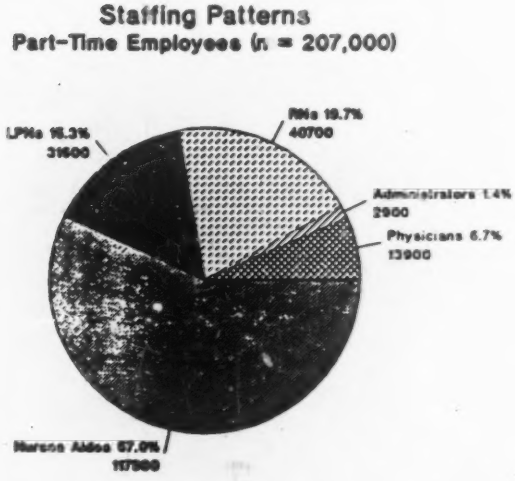
Behavioral Problem	*N*	%
Difficulty in communication	20	40
Delusions, hallucinations	19	38
Restlessness	19	38
Passive-aggression	19	38
Demands interaction	18	36
Socially objectionable	18	36
Disruptive	17	34
Active aggression	13	26
Verbal aggression	13	26
Wandering	12	24
Noisiness	12	24
Manipulativeness	11	22
Incoherent speech	10	20
Self-destructiveness	7	14
Elation	1	2
Destructiveness to property	0	0

Source: Rovner et al. (1986). Reprinted by permission.

Table 1



Source: National Center for Health Statistics (1978).



Source: National Center for Health Statistics (1978).

Figure 3

ESTIMATES OF PRACTITIONERS NEEDED TO SERVE THE ELDERLY

PRACTITIONER	YR. 2000	YR. 2020
ACADEMIC GEROPSYCHIATRISTS	400-500	400-500
ACADEMIC PSYCHOLOGISTS	180	900
GEROPSYCHIATRIST PRACTITIONERS	3,000-4,000	4,000-6,000
GERIATRIC NURSE PRACTITIONERS	19,000	25,000
SOCIAL WORKERS	40,000-50,000	60,000-70,000
PRACTICING PSYCHOLOGISTS	2,000	5,000-14,000

SOURCE: Personnel for Health Needs of the Elderly through Year 2020, U.S. Dept. of Health & Human Services, 1987.

Table 2

Even when geriatric expertise is available, however, current regulatory and fiscal policies may provide another barrier to effective geriatric care. Again, Borson and his colleagues (1987) summarize the effects of the current regulatory climate on psychiatric involvement in nursing homes:

> ...Medicare reimbursement for psychiatric consultation in the nursing home is no more favorable [than reimbursement for outpatient services]. Written consultation reports earn about $60, and no more than two follow-up visits can be reimbursed (at a rate of $35 each) over the next 60 days. There is no Medicare provision for reimbursement of a psychiatrist for time spent in consultation with nursing or aide staff. The time and expense of travel from a private office to a nursing home and the expense of the hiring secretarial help to manage cumbersome Medicare paperwork are, of course, out-of-pocket expenses for the psychiatrist. Finally, nursing home residents who do not maintain Medicare Part B coverage for nonhospital care have non coverage for these services (p. 1416).

Apart from the reimbursement rates, current regulatory restrictions may prevent the few geriatric practitioners from being fully available to older adults in nursing home settings. A clinical colleague recently provided an excellent example. She is a doctorally-trained psychologist who has had post-doctoral training in geriatric treatment. In short, she is exactly the type of practitioner you or I would want for ourselves or our older relatives. Because of current Medicare regulations, however, she is unable to provide services independently. As she reports:

> ...There has been considerable dispute lately about the relationship psychologists must have with a physician in order to be properly "supervised". Some interpret that to mean that the psychologist must be an employee of the physician, with the physician billing for the psychologist's services and paying the psychologist on contract. This is the arrangement we have used because we are trying to be so conservative on the issue. Think about what it takes to find a physician who is willing to bill for my services (taking on the liability for my work). Consider also that this puts me in direct conflict with American Psychological Association (APA) ethics concerning my position as an independent practitioner. Some local psychologists have been unwilling to see Medicare clients due to their belief that this puts them in a compromised position with the supervising physician which violates APA ethical principles (Qualls, 1988).

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Psychologists and physicians are not the only practitioners who need to collaborate to improve mental health care in nursing homes. The use of prescription medicines in nursing homes offers another primary example of a problem area that requires inter-disciplinary collaboration to improve the mental and physical health of older residents.

Polypharmacy in Nursing Homes

A recent report by the Inspector General of the Department of Health and Human Services summarized information on the use of prescription medicines in nursing homes:" Sixty-one percent of the institutionalized elderly receive three or more different prescription drugs in a year; 37 percent receive five or more; and 19 percent receive seven or more." (Inspector General, 1989, p. 5). At first glance, this intensity of therapeutic regimens may seem warranted, since many institutionalized elderly have both mental health and physical health problems (or comorbidity) (Cohen,1985; Lurie, 1987; Sakauye,1986).

When the therapeutic regimens of the setting are considered, however, there is cause for concern. Almost a decade ago, Wayne Ray and his colleagues at Vanderbilt reported on high rates of antipsychotic drug use in nursing homes (Ray et al., 1980): 43% of the Medicaid recipients in their epidemiologic study received antipsychotic drugs. This large-scale study was replicated recently by Buck (1988). Similar patterns of inappropriate regimens were reported by Burns and Kamerow (1988), using data from the National Nursing Home Study Pretest: 33% of their sample were receiving a psychotropic medication; 21% of those receiving a psychotropic medication had no diagnosis of mental disorder.

Mark Beers and his colleagues (Beers et al., 1988) presented a similar picture when they reported on a review of the medications used by 850 nursing home residents in 12 intermediate care facilities in Massachusetts. They found that more than half of these residents were receiving a psychoactive medication, with 26% receiving antipsychotic medication. Of greater concern, however, was the appropriateness of the regimens. Beers and his colleagues point out that prescribers continue to make less than optimal choices for geriatric drug treatment.

The effects of these medications was powerfully conveyed in a recent editorial by Hal Willard, a 61-year-old journalism professor, writing about his 94-year-old mother (Willard, 1989):

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> ...No matter how old you are, the first time your mother looks at you with blank eyes and speaks gibberish you are going to be shocked. She had been in nursing homes for a few years because of what was variously described as arteriosclerosis, hardening of the arteries, senility, and mistakenly, I think--Alzheimer's disease.
>
> The first shock came the day I walked into her room ...and found her in the chair, seemingly dozing. I put my hand on her arm and spoke to her softly. When she didn't respond, I spoke louder and shook her arm gently...Finally, she stirred and opened her eyes. I'll never forget the experession in her eyes. She was looking at me from someplace I hope never to go. Her normally pale, blue eyes seemed electric and burning. She began to speak, but there were no words; only sounds emerged, as if her mouth was stuffed with popcorn...

After describing a downward progression for his mother--including periods of blackouts and restraints in her chair--Willard commented:

> ...the slowdown in her life force was more apparent: she was stooped over, her walk was more of a shuffle, her thought process was almost nonexistent. She was becoming zombielike.
>
> I knew that she was being given something called Mellaril. ...I asked a pharmacist what it was and was told it was a tranquilizer...I didn't know it was what doctors call an antipsychotic substance and was a powerful tranquilizer administerd to keep patients quiet...
>
> I found out the truth about the drugs by accident. I transferred Mother to another institution...In her new home, Mother began to improve within a short time and in a few weeks she was her old vibrant self...I asked the nurses and her new doctor the cause of the remarkable improvement. They said they had merely stopped giving Mother Mellaril. She didn't need it...(p.10)

Beers (1989), in recent Congressional testimony, summarized the implications for nursing home residents, a population of vulnerable individuals: "It is likely that the wide-spread overuse and misuse of psychoactive medications add to the psychological woes of nursing home residents. First, when used inappropriately they may cause

depression, agitation, sedation, and confusion. Second, they may mask psychological disease and make depression, anxiety, and confusion difficult to recognize. As long as these medications are overused, the impact of increased non-pharmacological mental health services may be lessened."

The polypharmacy problem also affects another aspect of nursing home care: collaboration among nurses, physicians, and pharmacists. Florence Huey, editor of Geriatric Nursing, recently pointed out that the personnel shortages described earlier have a direct impact on patient care and therapeutic regimens: "...When you are the only nurse for 60 or more patients and each of your aides has an assignment of 15 residents, how much time will you find to "talk down" an elderly who is striking out at staff and other residents? Even if your years of experience with many newly admitted elders who became aggressive when they were depressed and grieving over their lost lifestyle warn you that an elder's belligerence may reflect fear, not psychosis, chances are you're overwhelmed. You hardly have time to pick up the phone, ask the physician to order "something for Mr. Brown", then sign the drug out and give it....The use of geriatric nurse practitioners in nursing homes to monitor medication regimens could help a lot." (Huey, 1989, p.119).

Lipton and Lee (1988), in a recent review of drug treatment for older adults, also highlighted the threat of polypharmacy for residents of nursing homes. They emphasized the importance of communication among nursing staff, physicians, and pharmacists. Equally important, they described California's experience in amending California's State Pharmacy Practice Act to permit pharmacists practicing in "licensed health care facilities" (such as nursing homes) to prescribe drugs under protocols established by the facility and authorized by the resident's physician. They concluded that HCFA should initiate demonstration projects and disseminate the findings of "pharmacist-as-prescriber" experiments.

A Word About Research

Lipton and Lee's call for additional demonstration projects in the area of drug regimens is consistent with a recently completed review of health service research in nursing homes (Beardsley et al., 1989). Beardsley and his colleagues point out the relative dearth of empirical research on the effectiveness of a variety of health services in nursing homes. Moreover, they highlight the worse than average funding and higher than average disapproval rates that such proposals have received in the NIMH peer review system. I agree with their assessment that

we need additional, well-designed empirical studies assessing the comparative advantages, differential costs, and differential outcomes of a variety of approaches to the mental health problems of nursing home residents.

A Word About the 1987 OBRA

Today's hearings are particularly timely because of the current debate and consideration of the implementation of the 1987 Omnibus Budget Reconciliation Act (OBRA) provisions. As you know, that act directs the Health Care Financing Administration to implement a number of far-reaching changes that affect both those who are treated in nursing homes and those who provide care. My comments today have summarized the situation for nursing home residents and staff before the OBRA provisions have been implemented. Thus far, because of judicial and legislative concerns, the future of OBRA implementation is unclear. At the very least, however, the preadmission screening and referral process may change either the diversity of older adults who seek services in nursing homes or their primary diagnoses. As the OBRA regulations are finalized and implemented, increased attention should be focused on the intended and unintended effects of the regulations (Smyer, in press).

Recommendations

My recommendations focus on three different elements: availability of service providers with geriatric mental health expertise; providing access to those service providers; and encouraging demonstration projects and research on cost-effective approaches to treating the mental disorders of nursing home residents.

1) In terms of availability, funds should be ear-marked for preparation of academic and clinical geriatric practitioners in the four "core" mental health disciplines of psychiatry, psychology, social work, and nursing. Current NIMH-funded efforts in this area should be continued and expanded, with an explicit linkage to service and training in nursing home settings.

2) In terms of access, recently proposed Medicare reconciliation provisions should be supported, since they increase older adults' access to clinical psychologists and clinical social workers. These provisions allow clinical psychologists and clinical social workers to be reimbursed by Medicare for mental health services, if the services would be paid for if furnished by a physician and if the clinician is licensed in the state to furnish such services.

3) In a related area, H.R. 1649, which provides for increased salaries for nursing home staff with the costs "passed through" to the Medicaid program, should be supported. This measure will enable long-term care settings to attract the qualified nursing staff necessary to appropriately provide the complicated pharmacological and other treatment regimens that nursing home residents need.

4) The Health Care Financing Administration should be directed to carry out demonstration projects assessing the cost-effectiveness and impact of several different approaches: projects focusing on pharmacists-as-prescriber and projects focusing on the role of nursing staff in the area of polypharmacy; projects focusing on the effects of training and other techniques to improve the functioning of nursing assistants as mental health as well as physical health care providers; projects assessing the impact of the 1987 OBRA training and pre-admission screening provisions on quality of care and mental health treatment for older adults who have both mental health and physical health problems.

Conclusion

Nursing homes are both mental health and physical health treatment settings. Epidemiological data clearly document that the majority of nursing home residents have a mental disorder. Additional data suggest that there are few geriatric mental health professionals currently working in nursing home settings. One result is that psychotropic medications are used more frequently than is appropriate. A variety of strategies are needed to make the settings more effective. Burns and her colleagues (Burns et al., 1988) summarized the needed next steps: "Enlightened reimbursement policies, innovative approaches to providing mental health services in nursing homes, improved training for caregivers, and more research on this topic are imperative" (p. 34).

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American Psychological Association

Advancing psychology as a science, a profession, and as a means of promoting human welfare

September 5, 1989

Congressman Edward R. Roybal
Chairman, House Select Committee on Aging
2211 Rayburn House Office Building
Washington, D.C. 20515-0525

Dear Congressman Roybal,

On behalf of the American Psychological Association I would like to thank you for providing our representative, Dr. Michael Smyer, the opportunity to present testimony about the mental health needs of elderly nursing home residents. Enclosed are Dr. Smyer's written responses to the questions you sent after the August 3 hearing. Dr. Smyer's comments on your bill H.R.111 are contained in those responses.

Let me say in general that APA endorses wholeheartedly the concepts outlined in H.R.111. We believe that expansion of Medicare and Medicaid coverage to include mental health care delivered by qualified, licensed professionals is critical to the mental and physical well-being of our nation's elderly. As you know, APA has devoted considerable attention in recent years to ensuring that elderly people receive the acute and long term care they need and deserve; in our view, these needs include basic mental health services. APA stands ready to help you and your staff in any way we can to ensure passage of legislation such as H.R.111.

To this end, APA has already begun to compile our already considerable resources to address the complex issues involved in mental health and aging. For example, to supplement the Division of Adult Development and Aging--an APA division with members who specialize in gerontology--the Practice Directorate has convened a special Advisory Task Force on Aging and Long Term Care. This task force is comprised of leading gero-psychologists (including Dr. Smyer) from research and clinical backgrounds who analyze aging and long term care issues from a broad perspective, and advise our office on treatment and policy solutions to identified problems. Through this task force we hope to serve as a resource to policy-makers on Capitol Hill. We have already distributed a copy of H.R.111 to leading gero-pschologists for review and comment and will provide you with this analysis when it is available. The activities of the task force also enhance our in-house "Databank" on psychological research and analyses bearing on prevailing policy issues, including aging and long term care.

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We are encouraged by legislation such as H.R.111 and look forward to working together with you to ensure that mental health care for elderly people receives the attention it deserves. Please do not hesitate to contact us if we can help you in any way.

Sincerely,

Bryant Welch

Bryant L. Welch, J.D., Ph.D.
Executive Director for Professional Practice

cc Representative Thomas Downey
Manual Miranda, Ph.D.
Yvonne Santa Anna

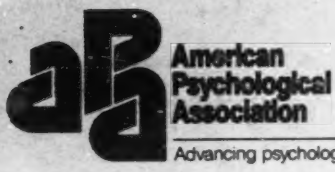
QUESTIONS FOR DR. MICHAEL SMYER, CLINICAL PSYCHOLOGIST; REPRESENTATIVE OR AMERICAN PSYCHOLOGICAL ASSOCIATION

1. You mentioned in your testimony that fewer than 1% of all nursing home patients with a diagnosable mental disorder receive explicit mental health services. Why is this happening? What can we do about this intolerable situation?

2. You refer to financing of services as one of the barriers to involvement of mental health care professionals in nursing home care. What suggestions do you have in the area of financing?

3. Would you comment on your perception of the OBRA 1987 act as it relates to the screening of nursing home patients with mental illness?

4. Your testimony refers frequently to inappropriate use of psychotropic medication in nursing homes. Is it your opinion that this stems directly from the lack of sufficient mental health personnel within the nursing home setting?



Advancing psychology as a science, a profession, and as a means of promoting human welfare

SUPPLEMENTAL TESTIMONY OF

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

OFFERED BY

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PENNSYLVANIA STATE UNIVERSITY

BEFORE THE

UNITED STATES HOUSE SELECT COMMITTEE ON AGING

ON THE SUBJECT OF

MENTAL HEALTH IN NURSING HOMES

August 30, 1989

1200 Seventeenth Street, N.W.
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INTRODUCTION

The following testimony responds to the written questions presented by Congressman Roybal after the August 3, 1989 hearing on mental health in nursing homes. The format follows the questions posed by the Congressman. Our analysis will focus primarily on the discipline that we know best, psychology; but the Committee should bear in mind that many of our arguments apply with equal force to the other core mental health disciplines.

1. Why do fewer than 1% needing mental health services receive care? What can be done?

The current system reflects several barriers to mental health service: Lack of incentives for nursing homes to provide mental health services; lack of funding for mental health practitioners such as psychologists who have the skills to provide effective mental health interventions; and lack of available skilled mental health personnel given the scope of the need. Legislative efforts such as H.R.111 and S.100/H.R.774 (direct Medicare reimbursement to clinical psychologists) are seeking to correct these conditions.

In terms of incentives, the current system provides almost no reimbursement for mental health services in nursing homes and, in some instances, even discourages accurate assessment and treatment of mental disorders. For example, nursing homes who accurately identify residents with mental disorders paradoxically run the risk of losing Medicaid funding if they are reclassified as Institutions for Mental Disease ("IMD"). This contributes to the "medicalization" of nursing home care, where mental health symptoms are inappropriately defined and treated in terms of antecedent physical causes. As a result, many residents are misdiagnosed or, even worse, receive psychotropic medications when safer, more effective psychological interventions are appropriate.

Congressman Roybal's recent bill, H.R. 111, acknowledges this problem. The language proposed in the bill seeks to mandate that Medicaid and Medicare include mental health care in plans of care. This will provide a major financial incentive for nursing homes to ensure that residents are accurately diagnosed and receive appropriate mental health services from competent mental health professionals.

Current practitioners who have geriatric expertise may also become more interested in the setting if current legislative initiatives mentioned in our written testimony become law. For example, Medicare is unique among virtually all existing health care plans in that it does not provide beneficiaries with direct access to psychological care except in community mental health centers and rural clinics. Representative Coyne and Senator Rockefeller are attempting to correct this situation through passage of

H.R.774/S.100, mentioned above. A copy of APA's testimony in support of this legislation before the House Energy and Commerce Health Subcommittee on June 8, 1989 is enclosed along with a list of current House and Senate Co-Sponsors. This legislation was passed out of the House Ways and Means and Energy and Commerce Committees (with an amendment relating to physician notification) and is currently pending before the Senate Finance Committee.

The lack of mental health services in nursing homes described in our written testimony underscores the need for legislation such as S.100/H.R.774 and H.R.111. Since only physicians currently receive direct Medicare reimbursement, many residents receive inadequate mental health care or no mental health services at all. Between 75 and 85 percent of all mental health services do not come from a mental health professional; instead, these services are rendered by general physicians who typically have less than three months of mental health training and are poorly equipped to detect, diagnose, or treat the mental health needs of the elderly (Swan and McCall, 1987). Many older people who do see their general practitioner risk having their mental health problem undiagnosed or misdiagnosed (Rovner, et. al., 1986). In fact, German, et. al., 1987 estimated that mental health problems are overlooked by general physicians in about 50 percent of elderly patients. The result is that potentially treatable disorders are left untreated, thereby exacerbating the mental health problem. For example, approximately 15 percent of potentially reversible dementias go unrecognized (Institute of Health and Aging, 1985).

While Medicare does reimburse psychiatrists, older people do not receive significant portions of their mental health care from them particularly in nursing homes; in fact, one expert concluded that "not one nursing home in the country has a full-time psychiatrist on staff" (Harper, 1986). There are several factors that contribute to this problem. Most significant, many elderly people do not have geographic access to a psychiatrist. A study conducted by Applied Management Sciences (1988) concluded, for example, that psychiatrists are not located in 2/3 of all U.S. counties. In contrast, psychologists could fill approximately 40 percent of that gap in mental health care coverage. A SysteMetrics McGraw Hill (1989) distribution study corroborated these findings: There are approximately 25 states in which 10 percent or more of the population live in counties that do not have a psychiatrist but do have one or more psychologists. In addition, 75 percent of rural elderly people (1,748,816) live in counties that do not have psychiatrists. About 30 percent of these rural elderly live in counties that have psychologists only.[1]

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[1]Again, it should be stressed that these data do not include geographic distributions of the other core mental health disciplines--social workers and nurses--whose presence in outlying areas could further meet the mental health needs of many nursing home residents, if their services were reimbursed.

Poor access to a very limited pool of Medicare-eligible mental health professionals contributes significantly to the problem of elderly people not receiving needed mental health services. Again, this means that residents primarily receive treatment for mental disorders from primary care physicians untrained in mental health care, which results in misdiagnoses and prescription of harmful medications. This situation can be improved dramatically by modifying Medicare and Medicaid law, as proposed in H.R.774/S.100 and H.R.111. Similarly, the changes in copayment mechanisms proposed under H.R. 111 should improve access to mental health professionals.

Finally, some initiatives outlined in H.R.111 make better use of those services that are available. For example, increased emphasis on collaboration among community mental health centers, area agencies on aging, and nursing homes offers one approach to "extending" the talent that is currently available. Moreover, the provisions in section 202 redefining Institutions for Mental Diseases removes a powerful incentive for nursing homes to misdiagnose mental illness. In addition, the provisions of H.R.111 that call for increased training efforts in the four core mental health disciplines are clearly in keeping with the suggestions outlined in our written testimony.

One aspect of H.R.111 bears special emphasis. Namely, the bill's focus on <u>interdisciplinary</u> mental health care delivery, where qualified, licensed mental health providers recognized under state law render care and receive reimbursement for their services, is a crucial concept. This notion of <u>inter</u>disciplinary care must be distinguished from <u>multi</u>disciplinary care; the latter often connotes that one of the core mental health professions, usually physicians, has disproportionate input into diagnosis, care planning, and treatment (see, for example, testimony submitted to this Committee by the American Psychiatric Association, p.12). In contrast, H.R.111 reflects clinical reality by recognizing that psychiatrists, psychologists, and other mental health professionals are all competent to diagnose and treat mental disorders in elderly people; that competent mental health professionals make appropriate referrals to physicians when possible physical problems are presented; and that an interdisciplinary range of diagnostic tools and treatment modalities should be applied to mental health problems in nursing homes.[2] H.R.111 also conforms to virtually every federal reimbursement program (except Medicare) in its direct reimbursement to clinical psychologists for services rendered (see p.5 of attached APA testimony). We encourage the Chairman to resist amendments by the medical

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[2]Please refer to the attached APA testimony regarding the expertise of psychologists to differentiate between organic medical problems masquerading as mental disorders, where referral to medical professionals is indicated, and affective or mental problems which respond to psychological intervention.

community that would require physician control over diagnosis and care planning. Instead, H.R.111 should retain its current interdisciplinary posture which acknowledges that mental health professionals already work closely with physicians and will continue to do so in the future.

2. Suggestions in the area of financing.

Any discussion of financing and costs associated with mental health care must be prefaced with a review of the savings that accrue from appropriate screening, diagnosis and preventative mental health treatment. On the one hand, current medical mental health practices create staggering costs for state and federal governments. Every year drug overdoses among elderly people cause 32,000 fractured hips from falls, 60,000 cases of parkinson symptoms, and 150,000 cases of memory loss and dementia (Office of the Inspector General, 1989). Adverse drug reactions have also caused 250,000 elderly hospital admissions a year (Office of the Inspector General, 1989). The annual cost of these practices in financial terms is staggering. The cost in human terms is immeasurable and especially tragic in light of the fact that many behavioral problems that lead to medication are amenable to psychological intervention.

In contrast, expansion of mental health services can result in substantial savings. Research consistently demonstrates that early, brief psychological intervention suited to the medical and social needs of the older patient can prevent unnecessary and inappropriate medical treatment (Mumford et. al., 1984). Psychological treatment of older people, particularly those who have undergone surgical procedures and those with rehabilitation needs, is unquestionably cost-effective and can off-set many medical costs associated with the care of the patient. For example, research shows reductions of one to two days in post-surgery hospital stays for elderly patients receiving psychological intervention (Mumford et. al., 1982). Significantly, data also indicate that the cost of psychological services is less than comparable psychiatric services; market forces further drive the price of psychiatric care down by 9% when psychiatrists and psychologists are allowed to compete in those states with freedom of choice statutes (Mitchell, 1984).

In terms of specific financing options, there are several approaches that could be helpful: First, demonstration projects that document the cost effectiveness of prompt and early mental health interventions used with the elderly should be undertaken. Costs assessment could be a major element of the demonstration projects proposed under Section 102 of H.R.111. Second, it may be appropriate to consider some sort of additional payment scheme, comparable to the now controversial catastrophic drug component, which would allow for some cost-sharing linked to ability to pay. In general, we support the approach outlined in H.R.111.

3. OBRA 1987 screening aspects.

The intent of the OBRA 1987 nursing home screening provisions is laudable: assuring the most appropriate placement for active treatment of mental disorders among the elderly. Unfortunately, implementation to date does not adequately reflect either the realities of "comorbidity" among older adults or the realities of active treatment options for the mentally impaired elderly. In addition, HCFA's draft regulations contain provisions that unnecessarily delay prompt placement of some elderly people who need nursing home care and result in increased costs to the program.

In terms of comorbidity, many older adults in nursing homes are in need of both mental and physical health care. Indeed, as described above, effective psychological intervention can have profound positive effects on physical health. Unfortunately, the converse is also true; neglected mental health problems can lead to physical decline and functional impairment. One major concern is that the elderly's mental health needs may become under-reported because of screening pressures and the lack of reimbursement for mental health services for those appropriately admitted. Appropriate interdisciplinary assessment and expansion of reimbursement for mental health care would help address this problem.

Moreover, for those who are deemed inappropriate for nursing home care because of mental illness, we must be sure that proper referral to active and effective treatment settings are made. Some are concerned, for example, that board and care homes will replace nursing homes as major receiving sites for mentally ill elderly. Board and care settings are even less prepared to provide high quality mental health care than are nursing homes. Community-based alternatives are similarly incapable at present to absorb a significant influx of elderly clients with mental health needs. Legislative initiatives such as H.R.111 should be implemented simultaneously with the OBRA 1987 screening provisions to ensure that the mental health needs of older people denied access to nursing homes are met.

Equally troubling is the way in which HCFA, and in turn the states, have begun to implement the screening process. Although OBRA is silent regarding which mental health professionals may perform the screens, HCFA has issued draft guidelines (soon to be published as proposed rules) which require that a board-certified psychiatrist review and validate every mental health evaluation. This provision, presumably included to ensure that physical problems masking as psychological symptoms are not missed, is disturbing in several respects. From a practical standpoint, the psychiatrist distribution data reviewed above suggests that such a validation requirement will produce significant delays in the screening process. In fact, many elderly people requiring prompt nursing home placement have been forced to remain (inappropriately) in hospitals while the mental health screen is validated by a board certified psychiatrist (HealthWeek, May 15, 1989, p.14).

Moreover, since psychiatrists are not found in many counties and nursing homes, their "validation" of mental health screens can consist of nothing more than a paper review of patients' charts, rather than the necessary in-person examination; furthermore, HCFA's guidelines do not require that these psychiatrists have any expertise in geriatrics. Finally, the screening process already requires that residents have a physical examination by a physician. The risk of missing a physical illness masquerading as a mental problem is thus minimized through appropriate collaboration between the physician and the mental health professional; psychiatrists, though Medical Doctors, do not routinely perform physical examinations and better than 80 percent do not consider themselves competent to do so (Patterson, 1978).

Most disturbing, the HCFA guidelines do not conform to sound clinical practice. Psychologists and other licensed mental health professionals are qualified to perform the required mental health screens with appropriate coordination with physicians. In fact, psychologists are among the leaders in testing and assessment, especially in the areas of neuropsychology and Alzheimer's disease. Diagnosis and treatment of Alzheimer's disease in particular requires a coordinated effort of many professionals. In the diagnostic process, psychological behavioral assessments of memory, mood, and functioning are combined with typical physician tests to rule out other disorders. Unfortunately, no single diagnostic procedure is definitive, and instead the pattern of findings is of concern. In this diagnostic process, psychologists, psychiatrists and other physicians collaborate with nurses and social workers to arrive at a comprehensive assessment. Likewise, the treatment of Alzheimer's disease requires a combination of environmental, psychological, and medical interventions. Again, all four mental health disciplines contribute. Psychologists develop and implement behavioral strategies to maintain effective functioning. Primary care physicians monitor health concerns. Nurses provide care for the Alzheimer's patient and the entire family. Social workers assist the family in a variety of transactions. The key point is that the process is truly interdisciplinary with proportionate input from each of the core mental health disciplines.

One final concern relates to consistency in the screening process nationwide. Because each state is free to devise its own assessment approach, there is little available in the way of a standard assessment technique. Standardized functional assessment scales for elderly people do exist and should be used in the screening process (e.g., Lawton and Storandt, 1984; Smyer, Cohn & Brannon, 1989). In addition, efforts should be made to document the outcomes of the assessment process so that adjustments in the program can be made to protect those with mental health needs. Again, perhaps some of the studies proposed in Sections 102, 104, 105, or 106 of H.R.111 could be focused on this issue.

4. Inappropriate use of psychotropic medications.

The inappropriate use of psychotropic medications in nursing homes has several causes, many of which have been addressed in our answers to the

previous questions. First, physician contact with nursing home residents is sporadic, with much of the day to day contact falling to nurses and nursing assistants. Second, those physicians who do have contact with the setting are not likely to have training in mental illness or know about effective treatment modalities to address mental health problems commonly found in nursing homes. Because of inaccurate diagnosis and lack of awareness of nonpharmacological care, physicians too often resort to medications which can complicate or even cause mental health problems (see answer to question 2 above). Third, as documented earlier, few psychiatrists practice in nursing homes. Fourth, the nurses, who make many of the decisions regarding "standing order" or "prn" medications, may not have much training in geriatric pharmacology. Fourth, there are currently few alternatives to pharmacological restraint that are as readily available and reimbursable for the nursing home setting. Geriatric mental health expertise could be effective in decreasing rates of agitation, depression, and disorientation. However, these labor intensive approaches are generally not tried because they are rarely covered under HCFA's or fiscal intermediaries' terms. Finally, alternatives such as the prescribing pharmacist program outlined in our written testimony may offer another mechanism for decreasing the inappropriate drug regimens in nursing homes.

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Mr. ROYBAL. The Chair now recognizes Dr. Baldwin.

STATEMENT OF BEVERLY A. BALDWIN, PH.D., RN, ASSOCIATE PROFESSOR AND COORDINATOR, GRADUATE MAJOR IN GERONTOLOGICAL NURSING, SCHOOL OF NURSING, UNIVERSITY OF MARYLAND AT BALTIMORE, BALTIMORE, MARYLAND

Dr. BALDWIN. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to come and talk with you today and to share with you some of my own experiences, both as a researcher-clinician, and educator in geriatric mental health.

My name is Beverly Baldwin and I am a geriatric mental health nurse-clinician and also sociologist. I have been involved in geriatric mental health research practice and teaching for the last 19 years. I am Associate Professor at the University of Maryland. I coordinate the graduate major in gerontological nursing at that facility.

My testimony this morning will focus on some of the issues that have been discussed and I guess I would say "amen, amen" to much of what you've heard, and you will hear it repeated throughout the morning, and that is the demographics, who are the people that we're talking about—the older people in nursing homes who need mental health services. I think we can't reiterate that enough except to say that the situation is growing more grave with inadequate services.

I will take a little bit of time to talk about a couple of our projects at the University of Maryland, which are collaborative with the Medicaid system in the State of Maryland, and which I think demonstrate that in fact there are many care providers in the mental health service area who could provide some of the services that you are going to hear about.

I don't think we need to reiterate the projections, the demographics of the aging group in nursing homes discussed over and over again, except one point I would like to make, and that is the fact that hospitals are changing very rapidly in our society. According to the National Association for Hospital Development, by the year 2000, one-third of all the current hospitals will be closed or will become very highly specialized technological institutions.

If that trend does continue, and it is anticipated that it will, the elderly who are now occupying the majority of beds in hospitals will continue to do so but their movement into the long-term care system, particularly into nursing homes, will be very different. We are going to find that nursing homes are going to be the community acute care hospitals that we knew 20 and 30 years ago. We are going to have a much sicker group of people in those nursing homes. And certainly their mental health needs or their potential for mental health, cognitive or emotional problems is going to remain and be exacerbated.

We know that nursing homes have become the mental health institutions for the elderly, starting in the 1960s with the movement of psychiatric patients out of State facilities and into long-term care and community facilities. We also know that 96 percent of all institutionalized mentally ill elderly reside in nursing homes.

I think it is important to note that in a 10-year span, from the 1977 National Nursing Home study, in which it was documented that approximately 50 percent of nursing home residents has some mental disorder to the 1984 pretest of the National Nursing Home study for 1985, it was found that over 68 percent had documented a mental disorder. I'd like to stress "documented", because out of the 31 percent who were not documented to have a disorder, over one-fifth of those were receiving psychotropic drugs.

I think an important area to look at and it's one that has been mentioned this morning, the use of chemical restraints and medications in nursing homes has become the primary treatment, has been and continues to be treatment for any mental disorder or an undocumented disorder in the nursing home population.

It is also interesting to note that out of the group of people who have been documented to have some type of mental disorder, particularly those with Organic Brain Syndrome, these tend to be the most frail and probably the older of the nursing home residents. Interesting also is that three-fourths of this group require assistance with mobility, bathing, dressing, toileting, and eating, so we're not only talking about their mental health, emotional or behavioral needs, but the fact that these people are also very physically impaired.

I think it has been mentioned—and I'd like to reinforce—that less than 1 percent of the 1984 pretest sample of people who had mental disorders were receiving any mental health services.

It's interesting to us at Maryland to look at what's happening with some of that data. We purchased copies of those data tapes so that we might look at the full 1,800 in the sample and really get a better idea of what kind of medications are administered on what occasions because I think it brings up some clinical questions. Why are people who are not diagnosed with a mental disorder receiving psychotropic drugs? When are they receiving them, and what effect do they have?

I think a second perspective for understanding or another one for understanding the current needs for mental health services is the fact that the people who provide the care—that is, the nursing assistants or nursing aides—are the least qualified and the most transient group of health care workers in the United States.

I must tell you that in my experience, this situation is getting much worse, not much better.

In addition to knowing that we have a number of people who are diagnosed with mental disorders in nursing homes, there's a very large group of undiagnosed, or nondiagnosed, group who present equally or even more problematic behaviors to nursing home staff. And there have been a number of documented studies—descriptive studies—which tell us that nursing home staff have a great deal of difficulty with certain groups of patients—they are the assaultive or agitated patient, those who wander or pace, and many of the patients with a dementia have this problem, those who are depressed or withdrawn, who have suicide potential or attempts, who are hypochrondrical, who hallucinate or have delusions, and those who are confused and disoriented.

Given the fact that most of the care is provided by people who have very little insight and understanding and training regarding

these problems, I think you can see the significance of why in the long run probably psychotropic drugs were used as a primary treatment.

Another reason I think we see a current need escalating is the fact that in the past and currently the thinking that nursing home care is physical care and reimbursement should be for physical care is an erroneous way of thinking.

The fact is that most people in nursing homes—and we've documented that very well throughout the years—have both a mental or emotional, behavioral and a physical problem, and it is those problems together that make people who stay in nursing homes very frail.

What are some of the barriers?

I just want to briefly mention one or two of those. First of all, I think that the institutional environment in nursing homes is based on the medical model, which is an acute care; a model that focuses on diseases, on illnesses, and on crisis intervention. And essentially I think we've heard a good bit about that in previous legislation; in fact, that's how reimbursement is set up.

The fact that we don't look at the interrelationship between physical and psychiatric illness is not clear—and that is an area that's very problematic, particularly with the elderly—because one treatment regimen, that is, even medications, might interfere with another, even a behavioral approach, to some problem; and I think we've underestimated the impact that this has.

Another barrier is that we have underestimated again the direct care provider. The typical nursing home aide, the person who works in nursing homes, comes from a personal and family environment that does not foster positive mental health experiences in that person, and it is usually compounded by failures, by negative attitudes of indifference, apathy, and cynicism.

Yet, these are the very staff who are expected to be polite, courteous, respectful, and providing care and compassionate attitudes toward residents.

What happens is that nursing aides and assistants becomes the adversary or develop an adversarial relationship with the residents who already have behavioral, mental or emotional problems. I think you can see the scenario here, and it might account for the very high turnover rate in many nursing homes, up to over 100 percent in some facilities.

Another barrier is the lack of nursing home administrators' ability to understand the need for mental health services. In my own experience, this has been one of the greatest barriers that we have—we have receptivity of staff, nursing staff, ancillary staff, to work with consultation, but many nursing home administrators still, because of the reimbursement restrictions and the fear of repercussions—including liability—do not want this type of patient.

A third area—and I do not want to belabor this because I know this committee addressed this issue last year—is the nursing shortage nationwide; which I must say again, we haven't hit the bottom on that, but it's getting much worse. If there's a shortage in hospitals—and I think you've seen that over the last few months, even documented greater in the last year—but certainly the shortage in nursing homes will continue to grow.

In 1988 in your hearing, you noted that 45 percent of nursing homes reported severe RN shortages. That number is up. Fifty-one percent stated they required more than 90 days to recruit staff. More and more they are using agency staff, which, of course, aren't familiar with nursing homes, the nursing home residents, and with therapeutic care.

What are some of the solutions? I am just briefly going to mention that, but before I do, I'd like to tell you about three of the projects that I've been involved in with the State of Maryland with the Medicaid system in which I think we've demonstrated some important avenues to access mental health services in long-term care.

Starting in 1977, a group of us at the University of Maryland started working with the mental Hygiene Administration to set up some type of mental health services, aftercare and follow-up that will provide a new way of looking at working with some of the behavioral problems that have been experienced by nursing home residents.

Since 1977, we have followed over 200 patients in over 70 nursing homes who have been relocated from State psychiatric facilities. Now, the State of Maryland Medicaid Administration has provided an incentive for these nursing homes in which they will reimburse them up to a 30 percent rate over the ordinary rate for that particular level of care for a period of 6 months in order that they take that patient into the home. These patients are well matched for their needs with the nursing home abilities.

We have followed them for the 6-month period of the funding. We visit them once a month for a 5-month period of time. And we have found that it's very interesting to note some of the issues that come up in what we've done and what we've observed.

The first year, during 1987 and 1988, most of our work with the nursing homes was strictly crisis intervention, going in and trying to keep the patient there, keep the staff able to deal with the behaviors of the patient.

During the last couple of years, our role has been much different in that we can work with the staff to better understand the long-term coping that's necessary. Some of these patients have been in State hospitals 20, 30 and even 40 years. So this has been a very exciting project because we've been able to look at different ways of managing both the behavior of the resident in the home and also working with the staff.

Another project we were involved in from 1987 through the end of 1988 was a staff development project we put into place in a proprietary nursing home. The goal of that project was to see what it would take in manpower and in experience to get a group of nursing home aides and licensed personnel to participate in a mental health curriculum.

We were in that nursing home for a year and a half, and it's interesting—we became the tenured personnel in that facility. We were there longer than the director of nursing. In fact, we went through three directors of nursing, through most of the nursing home aides, and through one administrator.

We put a 15 module curriculum in place for 8 months. We put a clinical specialist—a geriatric mental health clinical nurse special-

ist—half-time in the facility, and we actually implemented this program over a year and a half period of time.

It's interesting, we found on pre- and post-tests there was no change in learning from these staff members. I think it's important to underline that many of the training programs that are taking place, the assumption is, you teach someone something one time they'll learn it. The change was in the attitudes. We saw a very dramatic increase in the ability of the staff to be insightful toward the behavior of the patients, to be more relaxed about their own stress; and we really focused on the stress of the staff as much as the patients.

So that project has been revised, it's being published for distribution. But I think it's a good demonstration that in fact these types of training programs can take place very successfully.

The current project we're involved in, and one which I think will help to summarize my comments today, is one in which the State of Maryland—again through a nursing home incentive program—has a certificate of need designated bed project. Essentially all nursing homes who apply for a certificate of need must agree through a contract to provide a certain number of geropsychiatric beds for the number of beds that they are applying.

In order to do this, then once the home is built or they've expanded, they agree to take relocated psychiatric patients from State facilities into these homes.

The Mental Hygiene Administration, State of Maryland, have contracted with our group at the University of Maryland to actually provide the mental health consultation to these patients through the designated bed homes. And we've been doing that since July of 1988.

Essentially what happens, since we're contacted by the State, is when a home has received a patient, that home then is given—through us, through the contract—$1,000 per bed, per patient, per year, in mental health consultation services. A coordinator for that program is a clinical nurse specialist, a gerontological nurse specialist; what she does is go in and do an assessment of the patient, talk with the staff, decide what consultation is needed, and then we have a roster of a number of different mental health consultants who in fact provide that consultation. That includes nurses of all types, both geriatric mental health but also medical surgical nurses, public health nurses, clinical psychologists, social workers, other allied and mental health professionals, music therapists, occupational health therapists, and so forth.

What this project has demonstrated in 1 year is that there is a cadre of mental health professionals out in the field who are willing to conduct consultations and provide mental health services in nursing homes. But the access to that provision is very, very limited. There is no reimbursement for it, therefore, there are not people out there willing to do it, or able to do it. And nursing homes, the nursing home industry, as you know, has not taken a lead in really amplifying that and getting these people based on funding from their own sources.

So one of the things that I would like to leave you with is that, first of all, we don't need to continue to demonstrate that we need to provide mental health services in nursing homes. We know that

we need to do it. We also know that we have a group of mental health professionals who are willing and able to do that.

I agree with Dr. Smyer that numbers are very small, but they're growing very rapidly. And I think one of the incentives to get people into this field is knowing that there is an avenue for reimbursement, there's an incentive for them to go out and be able to practice in long-term care settings like nursing homes.

The access is absolutely limited now. The only people who can access to the mentally ill in nursing homes are physicians and psychiatrists. Even though they have a role in providing the long-term services that are needed, they are also very limited because the ongoing staff training that's needed, the ongoing meeting with both the nursing staff and the patients in helping them to cope really cannot be fulfilled by one health group; it has to be an interdisciplinary focus.

The other area I would like to reinforce is that we need, of course, more money, and research and in training in order to get people more interested in this field, I think the attraction is growing significantly. We know one of the most popular of the graduate programs in nursing has been psychiatric mental health nursing. There's no reason to believe that geriatric mental health nursing would not also be as popular.

I'd just like to close by saying that I hope through some of the testimony you hear today that you will come away with a sense that there are professionals who are willing and able to really provide services to the mentally ill in nursing homes—that number of people who are mentally ill in nursing homes is growing very dramatically, so we need to move rapidly.

The issue is access—if the Federal Government provides access, so will the States. It has been our experience that those projects where States are really interested in providing initiatives through Medicaid work, and they work very successfully.

Thank you.

Mr. ROYBAL. Thank you.

[The prepared statement and supplemental material submitted by Dr. Baldwin follows:]

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MENTAL HEALTH IN NURSING HOMES: BARRIERS AND SOLUTIONS

SUMMARY

The mental health needs of nursing home residents continues to increase, with over 68% having a mental disorder (including Alzheimer's Diseases and related dementias). The nursing home is the largest provider of care for the institutionalized mentally ill elderly. Even in the absence of a diagnosed mental disorder, it is estimated that over 80% of all nursing home residents exhibit some type of mental, emotional or behavioral problem which requires intervention. The primary treatment utilized in these homes for meeting those needs is medications, particularly the psychotropic drugs. The absence of behavioral and environmental approaches to meeting the mental health needs of the elderly creates chronicity and the inability of the individual to function at his maximum capacity.

Interest in new, innovative models of care for the mentally ill elderly is growing, with demonstrations initiated on a national level and include attention to the psychosocial and behavioral needs of the residents, manipulating the environment to accomodate the resident's potential and provide support and reinforcement of positive behaviors. Growing areas of research into behavioral interventions illustrate the potential for meeting the needs of elderly, in the absence of medications. Recognition of the interrelationship of physical and mental illness is prompting new approaches to assessing the resident's behavior, etiological factors, and anticipated outcomes from selected interventions. The next step in altering this system of care is to replace the now-dominated medical model with one which can access a wide range of mental health professionals, including nurses, physicians and psychiatrists, psychologists, social workers and allied mental health groups.

The challenge to attract more mental health professionals to this area of practice will be met through opening up avenues of research which will address

the complexity of needs and care for this group of society's population. Reimbursement mechanisms must be in place which recognize the expertise of all mental health professionals and which will have direct impact on the quality of care received by the elderly. Innovative and creative interdisciplinary training programs need to be developed in which professionals from a variety of disciplines can interact and assess and plan care.

The unmet needs of the mentally ill institu onalized elderly is a reflection, in part, of the type of health care delivery system represented by the nursing home, the number and type of employees in that setting and the historical practice of reimbursing physical, rather than mental health care. Recognition of the growing needs and the lack of resources have already opened dialogue for re-evaluating the costs to this segment of the population and the type of services required to meet those psychological and mental needs.

Current and future projections of mental health needs of nursing home residents must be considered within the context of society's changing demographics and the evolving status of the Nation's health care system. A phenomenal increase in the over-65 age population from approximately 12% in 1985 to over 13% in the year 2000 and over 21% by 2030 will impact all aspects of the health care system, particularly long-term care, in which estimates suggest the need for double the number of present nursing home beds by the year 2020. Confounded by these rapidly changing demographics of society is the evolution and change of the health care system itself. With almost one-third of today's hospitals anticipating closing or becoming more specialized by the year 2000 (National Association for Hospital Development, 1989), the type and level of care in acute, tertiary settings will change dramatically. Since the over-65 age group is a primary user of current hospitals, restricted services and high-tech care will mean shorter stays for this sicker high risk group. With the higher acuity level patients transferred from hospitals into long-term care institutions, particularly nursing homes, these institutions will assume the role of secondary acute care community hospitals. The current changes in the role and expectations of nursing homes are superimposed on their role of providing care for the chronically mentally ill elderly, created by the 1960s movement of the mentally ill out of state mental hospitals and into community long-term care settings. The complexity of the needs of the nursing home resident of today and anticipated in the future necessitates careful and systematic examination, by both the funders and the providers of the care to meet those needs. The mental health needs of nursing home residents merit immediate attention, since little research or clinical data are available on the fiscal or labor costs necessary to assess and care for elderly with those needs.

The Current Need for Mental Health Care in Nursing Homes

Since the mid-1960s, nursing homes have become the primary community mental health resource for the elderly. In fact, 96% of all institutionalized mentally ill elderly reside in nursing homes. The 1977 National Nursing Home Survey estimated a mental disorder rate above 50% (United States Department of Health, Education, and Welfare, 1979). Although some of the relocated geropsychiatric patients may receive improved care for chronic physical illnesses in the nursing home, a serious problem has been created by the lack of follow-up by mental health professionals and the inability of nursing home staff to adequately assess and intervene in the elderly's mental and psychosocial needs.

Preliminary analysis of data from the 1984 National Nursing Home Survey Pretest indicate that the rate of mental disorder has increased and the inadequacy of care continues. The NNHS Pretest (Burns, B., et al, 1988), was conducted in 112 nursing homes (a 75% response rate - 150 nursing homes were contacted) in four metropolitan areas - Atlanta, Boston, Denver and Toledo. Face-to-face interviews with staff nurses were conducted, in addition to chart review of sampled residents.

Of the total 536 residents sampled in the Pretest, 39% had a diagnosis of Organic Brain Syndeome (OBS), 29% had a diagnosis of other mental disorder (OMD), and 31% were judged not to have any mental illness. The overall prevalence rate of mental disorder is 68%, up from the 1977 NNHS. Of the Other Mental Disorders (OMD), the major conditions are: mental retardation (25.4%), depression (23.7%), schizophrenia (21.9%) and anxiety (16.7%). Residents with OBS and no other mental disorder are in their 80s (mean age was 82.4 years) and those with OMD are in their late 60s (mean age was 69.4 years). The average age of the remaining residents with no mental

disorder is 81.9 years. Seventy-four percent of the Pretest sample are female.

The OBS group was found to be the most frail, both physically and functionally, as indicated by over three-fourths of this group requiring assistance with mobility, bathing, dressing, toileting and eating. The availability and use of therapeutic mental health services (provided by psychiatrists, clinical nurse specialists, clinical psychologists, clinical social workers and other mental health professionals) are low - indicated in the Pretest by only 1% overall for the three groups and only 2% and 5% respectively of the residents with OBS and OMD! In CONTRAST, the use of psychotropic medications is found in all groups. Four psychotropic medication classes were analyzed: sedatives, antianxiety agents, andidepressants, and antipsychotics. The most frequently prescribed drugs are the antipsychotics, and, although the psychotropics medications are prescribed most often for residents with a diagnosis of OBS and/or OMD, 21.1% of the Pretest residents without a mental condition also received these medications during the week prior to data collection. The discrepancy between the use of a specific treatment in the absence of a disorder raises critical clinical questions: (1) what behavior (s) prompted the need for prescribing these medications; (2) when and under what circumstances are the medications administered; and, (3) what therapeutic effects are anticipated? The use of "chemical restraints" (psychotropic medications) may be not only inappropriate for these residents but may suggest a serious indictment of the nursing home care environment. In any case, these preliminary findings illustrate an urgent need to examine more closely the medical model now being implemented in nursing home care, particularly in the absence of other care models and/or therapeutic mental health services or interventions.

A second perspective for understanding the current need for mental health services in nursing homes focuses on the presenting behaviors some residents may exhibit (intermittently or consistently), regardless of mental disorder diagnosis, and which appear to be the most problematic and time-consuming for the direct care providers. These providers, nursing home aides, give 85% of the direct, "hands on" care in nursing homes.

Wykle (1986), in reviewing the nursing home literature for common behavioral problems nursing home staff face daily in the care of the elderly, stressed the complex needs presented by nursing home residents, the interrelationships between physical and mental problems, and the reality of staff's inability to assess and intervene in many of the behaviors presented by the elderly. The behaviors which staff find most difficult to understand and to manage include:assaultive/agitated behavior, wandering/pacing (both day and nocturnal), depression/withdrawal, suicide potential/attempts, hypochrondriasis, hallucinations/delusions, confusion/disorientation, and drug reactions. Given the multiple effects of medications and the potential for serious drug interactions, nursing staff often state they are not adequately trained to assess the therapeutic and deal with the side effects of potent antipsychotic drugs. One consequence is the hesitancy of some staff nurses to administer PRN (give as necessary) psychotropic medications when a resident's behavior indicates a need. Although psychiatric-mental health nurses are trained in recognizing and assessing early signs and symptoms of escalating problematic behavior in patients and understand the relationship between the timing of administration and the therapeutic window effect, these skills are not systematically built into the training programs designed for nurses in long-term care settings. In fact, many staff nurses in long-term care admit to being afraid or apprehensive of the resident exhibiting inappropriate or non-compliant behavior, resulting in a lack of attention to the early

symptoms. Since the focus of nursing home care has been in the past, and continues to be on the physical care needs of the residents, nursing staff want to find a physical or organic cause or etiology for behavior; if that if not possible, they express feelings of inadequacy in assessing and managing the mental, emotional or behavioral needs of the resident.

The Barriers to the Provision of Mental Health Care in Nursing Homes

Although the need for mental health care in nursing homes has been well documented for the last twenty years, numerous barriers prevent or mitigate the implementation of effective therapeutic care. First, the institutional environment in nursing homes is based on the acute care, medical model, with a focus on diseases, acute illnesses and acute (including crisis) care. This model permeates the philosophy and provision of care, even though nursing home residents present chronic illnesses, multiple and often interactive. The interrelationship between physical and psychiatric illness is not clear in the elderly and may become problematic if one treatment regimen interferes with the therapeutic effects of other needed treatments. Incentives in the form of financial reimbursements for developing other models of care have not been available up until recently.

Since the majority of direct care is provided to nursing home residents by the least trained and often, the most stressed, staff members, the mental health care of the residents may go unrecognized or ignored. Tellis-Nayak and Tellis-Nayak (1989) studied the impact on care of the merging of the nursing aide and resident cultures. They suggest that the "typical" nursing aide comes from a personal and family environment which has not fostered positive mental health experiences and which is usually compounded by failures, conflicts and

attitudes of indifference, apathy, and cynicism. Yet these are the very staff who are expected to be "polite", "courteous", "respectful" and provide caring, compassionate attitudes toward residents while administering the most personal of care, such as bathing, feeding, toileting and dressing. The nursing home environment does not take into account the mental, emotional or behavioral needs of the staff; therefore, the attitudes often expressed toward residents is a reflection of the staff's coping with the stresses of the workplace and personal problems. Coupled with low pay and low status, the direct care provider may become an adversary of the resident - a vicious cycle which is evidenced in the high turnover rate (over 100% in some facilities) among this workforce.

In the past, nursing home administrators have faced financial penalties for providing care for psychiatric patients, since Medicaid policy classified as institutions for mental diseases (IMD) any long-term care facility where more than half of the patients had a diagnosis of a mental disorder. A revised Medicaid ruling in 1986 allows residents with senile and presenile psychiatric conditions to be excluded from the classification of psychiatric patient. Although allowing a broader category of patients to be certified for nursing home care, many nursing home administrators are still reluctant to admit or consider admitting patients with a psychiatric diagnosis (including dementia) unless the primary problems are physical in nature and reimbursement is assured. Additionally, many administrators lack understanding of the problems and needs of the mentally ill elderly, fearing the staff will be unable to cope with resulting problem behaviors.

The Nation's nursing shortage is an additional barrier to meeting the mental health needs of nursing home elderly. The impact of this labor shortage has been addressed in recent Hearings (September, 1988) by this Committee. The Interim Report of the Secretary's Commission on Nursing

(July 1988) indicated that 45% of nursing homes reported "severe" RN shortages; 51% stated they require more than 90 days to recruit RN staff. The shortage is evident with both LPNs (Licensed Practical Nurses) and with nursing aides, which is the most transient of the three groups and generally, the most difficult to retain in the work setting. Given the instability and understaffing of nursing home workers, the needs presented by nursing home residents become more overwhelming. The reality is that mental, emotional and behavioral needs of residents require more understanding, insight, judgment and problem-solving than the more simple, clear cut physical needs more commonly presented. Mental health needs cannot be treated as tasks to be carried out - dramatic changes in behavior are usually not evidenced and resident feedback or confirmation of positive responses to therapeutic endeavors is often nonexistent. With both chronic undertaffing and lack of adequately trained staff, the mental health needs of nursing home residents often go ignored, or, if necessary, handled on a crisis basis. Little anticipatory planning of care and follow-up can be observed in these settings. Reinforcing this type of staff response is the general limited amount of intervention research available which guides staff assessment and therapeutic approaches and which provide criteria for anticipated outcomes.

Solutions to the Provision of Mental Health Care in Nursing Homes

The medical model was cited as one barrier to effectively meeting the mental health needs of nursing home residents. Lindeman (1986) in a review of several proposed alternative models of long-term care, suggests innovative research and demonstration projects which tests out these models in different types and levels of nursing homes. One alternative is the social

model, suggested by Tolliver (1983) which focuses on a wide spectrum of care, with health care being only one component. The modified medical model (Gallard, 1982), would focus on the psychiatric problems and care of the nursing home resident, with the use of a range of health care disciplines, the physician remaining the primary provider and coordinator of care. A third model is the alternative academic affiliation, which links nursing homes with academic schools of nursing. The Robert Wood Johnson Foundation funded 11 such models in the 1980s with promising results. Nursing faculty had joint appointments with the nursing home and school of nursing; specific nursing problems and solutions were put into place and demonstration projects successfully completed on commonly occurring problems such as urinary incontinence, wandering behavior, decubitus ulcers and skin care and infections. One of the successful projects to focus on a nursing model was implemented in the Teaching Nursing Home Project in Oregon, affiliated with the Oregon Health Sciences Nursing Faculty and the Benedictine Nursing Center in Mt. Angel, Oregon. Several intervention protocols have been initiated with Alzheimer's Disease patients, including an exercise, movement therapy, to reduce wandering and pacing of these cognitively impaired residents. Another nursing model, also implemented in Portland, Oregon, concentrates on maximizing the functional capacity of mentally ill elderly and patient care planning and daily assessments conducted by an interdisciplinary team headed by a nurse. The focus is on promoting health and independence in activities of daily living, and the changes in the chronically ill elderly's behavior have been remarkable. Other,similar models, are in the planning or implementation phases in both acute and long-term care settings.

A fourth model is frequently cited in the research literature as a behavioral or environmental model (Avorn and Langer (1982). The needs of

the residents are viewed as a response to the environmental setting. Promoting resident control over the environment, educational support and retraining and group facilitation are examples of studies completed utilizing this framework. The fifth, or nursing model, has been proposed by Shields and Kick (1982) and places the nurse as the primary provider in long-term care, which would necessitate increasing the number of RNs in long-term care and the amount of time professional nurses spend with direct care of residents. This model, although altering the current manpower requirements, has been partially demonstrated through the RWJ demonstration Teaching Nursing Homes, with long-term success.There is a need to now demonstrate how the RWJ projects could be applied in varying degrees throughout other nursing home settings, even those in which affiliation with a nursing school is not feasible.

A second potential solution for meeting the mental health needs of nursing home residents is to develop new training models for all mental health disciplines which include content and experiential practice with the chronically mentally ill elderly and in nursing home settings. Since most health care professionals are trained in acute care hospitals or in non-institutional community agencies, exposure to the realities of nursing home care and outcomes is limited. Currently, few undergraduate medical or nursing students have a formalized clinical rotation in a nursing home, or with geriatric patients as a specific, defined patient population with unique and complex needs. Society's negative attitudes toward aging and the aged, as reflected in health care professionals (and students) will only be reversed with exposure to and respect for the this segment of our population. Although over 70% of all nurses work in hospitals, and hospitals are major settings for the acutely ill elderly, few professional nurses have had formal preparation in

gerontological/geriatric or geriatric mental health nursing. Response from both medical and nursing academic settings has been slow, but new programs in the undergraduate and graduate levels, initiated or being planned within the last five years, are encouraging signs of the positive response of health care professionals. Increased funding for these academic programs, and for the demonstration affiliation models described earlier, is imperative if the momentum is to continue. Scholarships/fellowships for students to focus on care of the elderly and innovative career ladder models are necessary to increase the qualified manpower pool to meet the growing needs of our aging society.

A third solution to greater understanding of the mental health needs and appropriate care of nursing home residents is to encourage research into nature and extent of the mental health problems of nursing home residents; improve the capacity of staff to deliver therapeutic care to this age group; and, study the type of nursing home environment which fosters positive mental health and optimal functioning. Evaluation of the appropriateness of specific interventions for troublesome and problematic behaviors exhibited by nursing home residents is needed as well as the testing of new, innovative behavioral and environmental interventions. An important conference, titled "Mental Illness in Nursing Homes: An Agenda for Research", was held in the fall of 1983, under the auspices of the National Institute of Mental Health (Harper and Lebowitz, 1986). The gaps in knowledge of the mental health needs of nursing home residents and foci for a research agenda are detailed in a series of 24 chapters - papers presented by researchers, clinicians, and policy-makers in long-term care and geriatric mental health. This interdisciplinary conference underscores the importance of this area of research and the need for interdisciplinary as well as discipline-specific research into both

care and outcome issues.

Models of Mental Health Care in Nursing Homes

Since 1986 I have been collaborating with colleagues from the School of Nursing, University of Maryland, on a number of nursing home projects which focus on staff training and the provision of services targeted at meeting the mental health needs of nursing home residents.

The first project was the development and implementation of a behavioral management curriculum for nursing staff which would address the most commonly occurring behavioral problems among nursing home residents, stress and stress management for the staff, and management strategies for all levels of nursing staff. The project was funded by a private foundation with contribution of a one-half time gero-psychiatric clinical nurse specialist by the State of Maryland Department of Health and Mental Hygiene. A fifteen module curriculum was developed and implemented over an eight-month time frame. The nursing home was a proprietary 184-bed intermediate care facility with the majority of residents Medicaid-reimbursed. Over 200 staff members (licensed and non-licsenced nursing staff) were employed, most parttime. The goal was to develop a training program which could be implemented with at least 50% of the staff. Since the facility did not permit classes to be longer than 30 minutes in length, each module was taught 9 times to cover the 112 staff members who agreed to participate. Classes were seminar-type and all taught by University faculty or graduate-prepared clinical specialists. On even weeks, the module would be presented, along with homework and review exercises, and on odd weeks the clinical nurse specialist would work in the facility one-half time and demonstrate to staff how to implement the strategies taught in the modules. Each staff

member had the opportunity to work independently with the clinical specialist since she alternated shifts and the modules were presented on all shifts and on weekends, when most of the parttime personnel were working. Examples of modules include communicating with the nursing home resident, stress management for staff members, working with the depressed and withdrawn resident, understanding Alzheimer's Disease and related dementias, working with the aggressive and hostile resident, etc. A module was also included on working with the family of nursing home residents. Licensed staff (26 in number) had two additional modules, on psychotropic medications. Seventy-eight of the 112 staff members completed the training program, with 20 of those attending 13 of the 15 sessions and 5 staff members attending all of the sessions. Although staff knowledge did not increase significantly, based on pre/post test scores, the attitudes of the staff toward the residents and their behavior changed significantly. Follow-up interviews with staff members after completion of the program indicated a greater awareness of the residents' mental, emotional and behavioral needs, less resistance to the demands of the residents, greater insight in to the meaning of some of the behavior observed among the residents and a better understanding of how the nursing home environment creates stress and specific stress management techniques which work for the individual staff members. The impact of the geropsychiatric clinical specialist on the staff and facility was significant and the nursing home now has a fulltime geropsychiatric clinical nurse specialist who works with both staff and residents. The most informative outcome of the project was a better understanding of the incentives and attitudes necessary to motivate satff members to want to learn more about the behavioral and mental health needs of the residents and to apply that learning. Tangible incentives for learning, such as door prizes, food, small gifts, certificates of completion and monetary reward for completion of

the program were very important to the staff and reinforced the trainers' interest in them as individuals, working under difficult conditions with stressful problems. Numbrous "train-the-trainer" series were developed from this project and presented to other nursing homes in the metropolitan Baltimore-Washington area and the curriculum has been further developed, revised and is now in preparation for publishing and distributing nationally.

Since July 1987 I have worked, along with a nurse colleague, with Maryland's Mental Hygiene Administration to provide aftercare follow-up for elderly and other appropriate state psychiatric hospital patients relocated through a nursing home incentive program. For the nursing homes agreeing to accept the appropriately matched state psychiatric hospital patient, the MHA and Medicaid developed a Patient Management Transition Fee to facilitate such placements. Through this program, nursing homes are reimbursed a fee equal to 30 percent above the usual rate for nursing homes heavy care services for a period of 6 months after the placement of a patient who is transferred from a special psychiatric or chronic care facility. As follow-up coordinators, our role has been to provide five visits during the first six months after relocation, to assess the resident's coping level and adjustment to the nursing home setting and to work with the nursing home staff and administration to better understand and meet the needs of the patient. Since 1987, my colleague and I have followed over 200 relocated patients in the Central Maryland Region (Baltimore City, Baltimore County, Anne Arundel County, and Montgomery County) in approximately 70 nursing homes. The age range is 26 to 96 years, with a mean of 69 years. Over two-thirds are women and the majority are caucasians. The psychiatric diagnoses vary widely, but the majority would be classified in the organic brain disorders (Alzheimer's Disease, dementias) and other mental disorders (depression, schizophrenia). Over 90% have

have one or more physical diseases which are concomitant to the psychiatric illnesses. These include cardiovascular, pulmonary and other systems, in addition to seizure disorders, diabetes mellitus and arthritis. During the first year of the aftercare, our main activity with the nursing homes appeared to be crisis intervention and short-term staff consultation and training. Work with the individual residents, except for ongoing assessment and evaluation, has been minimal. The behaviors the nursing staff appear to have the most difficulty in tolerating are the outwardly aggressive/disruptive and the inappropriate and noncompliant resident. Each nursing home expresses a type of tolerance level for these behaviors and when intolerable, have resulted in the return to the state facilities. A low rate of return has been realized, with less than 20% over the two years. It has been necessary to work with staff on both the physical care and mental health needs of the relocated residents; since the physical health of some of the relocated patients was frail and the vigilance of the nursing home was considerably less consistent than that of the state facilities. Nursing staff's ability to understand, assess and manage the behaviors of these chronically mentally ill patients varies from home to home, but generally, their level of knowledge and skill is minimal. All the nursing homes participating in this project have been receptive to the follow-up and aftercare consultation.

Since July 1988, the MHA has contracted with us to provide coordination of mental health consultation services for Designated Nursing Home Beds for GeroPsychiatric Patients. Nursing homes agreeing to designate a specific number of geropsychiatric beds as part of the contract for a certificate of need, are identified by the MHA staff and when a patient is relocated from a state psychiatric facility, we assess, plan and coordinate the appropriate mental health consultations to facilitate the adjustment of the patient to the nur-

sing home setting. The project is coordinated by a clinical nurse specialist in gerontological nursing, who has extensive clinical experience in both acute and long-term care, including being director of nursing of a nursing home and developing a Alzheimer's Unit within a nursing home. A roster of mental health consultants has been developed over the last year and includes geropsychiatrists, geriatric mental health clinical nurse specialists, other clinical nurse specialists (with expertise in urinary incontinence, and other physical disabilities), gero-psychologists, geriatric mental health social workers, music therapists, occupational therapists, activity therapists. Each nursing home is eligible for $1,000.00 in mental health consultation per designated bed per year. The Coordinator assesses the needs of the relocated resident and works with the nursing staff to identify the type of consultation needed. Follow-up of the consultation and facility implementation of consultant suggestions are monitored closely. It is anticipated that approximately 150 patients will be placed in the designated beds over the next fiscal year, which includes approximately 20 nursing homes. The response of the nursing staff to this project has been positive and the project demonstrates, not only the feasibility of mental health consultations in nursing homes, but the impact on patient care which systematic mental health services can provide. The interdisciplinary approach has been well received, and, in some situations, nursing home staff have the opportunity to work with mental health professionals for the first time.

Solutions to the Current Shortage of Qualified Providers of Mental Health Care for the Elderly in Nursing Homes

The cadre of mental health professionals qualified to work with the chronically mentally ill elderly is growing slowly, however, the financial incentives for concentrating in this area of practice are not present at this time.

The primary care provider of services remains the physician and the psychiatrist, and, with some exceptions, the nurse practitioner. Until the need for an interdisciplinary approach to meeting the mental health needs of residents in nursing homes is recognized, the attraction to this area of practice will remain low. The Robert Wood Johnson and the National Institute on Aging Teaching Nursing Home initiatives provide prototyes for understanding how research, practice and reimbursement mechanisms can be initiated in nursing homes, through collaborative efforts with nursing and medical schools.

The nationwide nursing shortage will continue to influence the quality of care provided in nursing homes, including mental health care. The recently completed study of the nursing shortage by The Commonwealth Fund indicate four major reasons for the increased demands for professional nurses: the rapid changes in medical practice and the use of sophisticated technology in hospitals, the aging of the patient population in hospitals, which is also reflected in the growing number of very old in nursing homes, the changes within the nursing profession itself and the economics of hospital care. Of the 200 plus graduate programs in nursing listed in the National League for Nursing Directory for 1986, only five indicated the opportunity for specialization in gero-psychiatric nursing, even though psychiatric-mental health nursing has been one of the most popular of the specialty areas in nursing for the last 20 years. The shortage of students seeking graduate preparation in nursing echos the diminishing number of nursing students at all levels. Therefore, for the specialist in geriatric mental health nursing to be recruited to the nursing home setting, numerous changes in the system and the response to the professional have to be made.

The fostering and increased funding for geriatric mental health research is one avenue to attract qualified professionals to the field. Although reference to the need for more research has been made in earlier sections of this

testimony, additional research into all levels of mental health care and services for the nursing home resident will attract health care practitioners who might not have considered this area of practice or who have been negatively influenced by the nursing home environment.

The support and funding of training programs, both formal and continuing education programs, is essential for the numbers of qualified mental health professionals to increase. The movement toward interdisciplinary programs, particularly interprofessional practice settings, will also reinforce the attraction to this area of geriatric care.

Although the barriers to providing quality mental health care to nursing home residents appear numerous at first glance, I am confident that many of the appropriate solutions to understanding the needs of the residents and attracting the qualified professionals have been identified and can be implemented over time. As society continues to age, much of the "ageism" of the 1960s and 1970s is giving away to "seeing" the composition of today's population. As "baby boomers" continue to age, we see evidence that "aging well" is becoming more fashionable, acceptable and sought-after. The changing attitudes of society in general will be reflected in attitudes of health care professionals, particularly as we prepare for entry into the the 21st Century.

QUESTIONS FOR DR. BEVERLY BALDWIN, ASSOCIATE PROFESSOR AND COORDINATOR OF THE GRADUATE MAJOR IN GERONTOLOGICAL NURSING, UNIVERSITY OF MARYLAND -- BALTIMORE

1. You stated in your testimony that 96% of all institutionalized mentally ill elderly reside in nursing homes. What proportion of this 96% actually need to be in a nursing home due to physical disabilities? What alternatives need to be developed for those mentally ill elderly not possessing serious physical disability?

2. You outline a number of potential models in providing mental health services in nursing home settings. In view of Congress' strong concern about budget constraints, which of these models possess effectiveness as well as cost efficiency in meeting the mental health needs of nursing home patients?

3. You note that the presence of a geropsychiatric clinical specialists on the staff of a nursing home had a significant impact. Do we currently have enough trained clinical specialists to serve as trainers for all nursing home staff? If not, what do you see as the most efficient means for achieving such a goal?

4. What are your suggestions for improving access to mental health benefits under Medicare and Medicaid?

RESPONSES TO QUESTIONS FROM THE HEARING OF AUGUST 3, 1989: MENTAL HEALTH AND THE NURSING HOME

TESTIMONY BEFORE THE SELECT COMMITTEE ON AGING: U.S. HOUSE OF REPRESENTATIVES

August 3, 1989

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1. What proportion of the institutionalized mentally ill elderly actually need to be in a nursing home due to physical disabilities? What alternatives need to be developed for those mentally ill elderly not possessing serious physical disability?

Of the 96% of all institutionalized mentally ill elderly residing in nursing homes, it is estimated (based on the 1982 GAO Report, 1977 National Nursing Home Study and the 1982 National Institute of Mental Health Survey) that 10% have a major mental illness without a physical illness. However, of those 10% (over 70,000 residents), it is difficult to determine how many need help with activities of daily living, minor illnesses, medication reactions/side effects or other potentially physical health alterations. It is anticipated that as these mentally ill elderly age, the onset of serious chronic illnesses will necessitate care which addresses physical health. Since the majority of mentally ill elderly enter nursing homes from hospitals or from the community, it can be assumed that they will already have some type of physical health problem, even though transient, such as incontinence, recently prescribed medications, nutritional problems or a deficit in one or more of activities of daily living (i.e., toileting, dressing, eating, mobility).

A variety of alternatives could provide care for those mentally ill elderly not currently experiencing serious physical illnesses, such as domiciliaries, group shelter homes, bed and board homes connected with adult day care centers and private home care, with adequate community mental health resources. It would be essential that non-institutional settings, including care of these elderly in the home, have access to regular, ongoing screening by health care professionals to ascertain the elderly's need for physical evaluation and care. An interesting model for this type of alternative is in the Veterans Administration Hospital/Medical Center System, which has developed domiciliaries with fulltime nurse practitioners on staff. The residents in the domiciliaries have

regular monitoring of their physical and mental health needs in addition to access to intermittent and episodic assessment and care. Since the interaction of physical and mental problems in the elderly place many at high risk, the non-institutional alternatives to nursing home care will need to have adequate resources in place to recognize and treat those problems in early stages of onset.

2. What are some cost-effective models for providing mental health services in nursing home settings.

Several of the models I suggested in my testimony of August 3 have the potential for being cost-effective, but the one model which would provide the most cost-effective high quality care over time would be one that utilizes the expertise of a variety of mental health professionals and does not rely on just one, the physician, to meet the needs of residents and staff in the nursing home setting. Each of the core disciplines in geriatric mental health - nursing, psychiatry, psychology and social work, have different skills and knowledge in the area of geriatric mental health. The gero-psychiatric clinical nurse specialist would have greater expertise in working with staff members on behavioral and psychotherapeutic approaches to managing resident behavior than the others and the physician would have expertise in diagnosis and medical management, etc. Our current project at the University of Maryland School of Nursing with the State of Maryland Mental Hygiene Administration uses such as approach: the coordinator of the project, along with nursing and medical staff in the nursing home, assess the resident's need (s) for mental health services/consultation and the appropriate health care professional to provide those services. The coordinator then arranges the consultation from the appropriate person (s), does the follow-up of outcome, and the nursing home evaluates the services at to effectiveness and outcome. The consultant's

assessment and plan of treatment/care/follow-up of the resident is placed on the elder's nursing home chart after the visit (s). This model is similar to many of the case management models in gerontology/geriatrics which have been demonstrated cost-effective in the community care of the elderly. The advantage of this model, both from a quality of care perspective and from a cost-effective alternative, is that the expertise of a variety of health care professionals can be accessed and utilized - there will not be over utilization of one particular professional in order to cover all the needs of an individual resident for services in addititon to working with the staff to implement and monitor a plan of care over time. An important point to emphasize, regardless of what type of geriatric mental health service model is in place, is that in addition to meeting the individual needs of residents in nursing homes, the mental health consultant/provider must also work with the direct care staff over time who must implement and monitor the care of the elder with mental health needs. Since 85% of all direct care is provided by non-licensed staff, the recipient of mental health services in the nursing home does bot stop with the resident. In addition, long-term follow-up, reinforcement and reevaluation of the resident receiving mental health services is essential, since the mental, behavioral and emotional problems of elderly in nursing homes are ongoing, cannot be "cured", and will likely exacerbate from time to time.

3. Do we currently have enough trained geropsychiatric clinical specialists to serve as staff developers and trainers for all nursing home staff? If not, what is the most efficient means for achieving such a goal?

Currently, there are few masters' prepared clinical nurse specialists in geriatric mental health. The exact number is difficult to determine, due to the lack of certification in this area and the minimal number of graduate programs in nursing which offer this area of specialization. Up until recently,

few nurses seeking graduate preparation in gerontology or psychiatric/mental health nursing would select such a specialty, primarily because the opportunities for jobs in this area were minimal. Most nursing homes in the U.S. today do not recognize the importance and necessity for geriatric mental health services/training; therefore, they do not employ specialists in this area. Clinical nurse specialists have not had the opportunity, therefore, to practice in most long-term care settings. The number of specialists in geriatric mental health have been increased substantially in the last five years, due to the training and practice initiatives in this area funded by the National Institute of Mental Health. A 1986-87 Conferance of nurse-educators in psychiatric-mental health nursing, sponsored by NIMH, identified psychogeriatric nursing as one of the three major areas to address in educational curricula for the 21st Century. The Robert Wood Johnson Teaching Nursing Homes have demonstrated the impact on the residents and staff of trained specialists in gerontological nursing, including geropsychiatric clinical nurse specialists.

In addition to funding national demonstration models, such as the ones discussed in my testimony, funding of training for nurses in geropsychiatric graduate programs and for continuing education for clinicians and for faculty must be increased - increased funds for the National Institute of Mental Health and the Division of Nursing, USPHS, with initiatives in training - would provide important avenues for schools of nursing to develop and implement these needed programs. With changes in the reimbursement mechanisms for providers of mental health services in long-term care, including nursing homes, changes in job opportunities for clinical specialists will occur. More nurses will can then be recruited to an area of practice in which their expertise, not only in trainig, but in direct service and consultation, can be utilized and adequated reimbursed.

4. What are your suggestions for improving access to mental health benefits under Medicare and Medicaid?

Nursing home residents present an array of complicated health care problems and the interaction of mental and physical health needs are not fully understood or recognized. Improved mental health benefits under Medicare and Medicaid must address the complexities of the elderly in nursing homes in addition to the narrow position that reimbursement takes currently when defined to medical diseases and diagnosed illnesses. This type of reimbursement mechanism eliminates the potential risks to nursing home residents of unrecognized and untreated behavioral, mental and emotional problems which do not fit the psychiatric diagnostic nomenclature.

The second area which needs to be addressed if mental health benefits are to be improved is the inclusion of non-medical health care providers of services, including nurses, psychologists and social workers. This Committee has moved positively in obtaining reimbursement for psychologists and social workers providing services in nursing home settings. The next step is to include, in both Medicare and Medicaid reimbursement legislation, other professionals who can offer the services needed by this population. The interdisciplinary approach to geriatric mental health services is not only appropriate, but could be cost effective, since the overlap of services, duplication of efforts and frequency of additional services (including hospitalization in acute care settings) could be addressed more efficiently.

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B. Baldwin: Testimony
August, 1989

Mr. ROYBAL. Dr. Fogel.

STATEMENT OF BARRY FOGEL, M.D., CHAIRMAN, CORRESPONDING TASK FORCE ON GERIATRIC PSYCHIATRY IN THE PUBLIC MENTAL HEALTH SECTOR, AMERICAN PSYCHIATRIC ASSOCIATION COUNCIL ON AGING

Dr. FOGEL. Thank you, Mr. Chairman.

I'd like to acknowledge your efforts and also those of your co-chairman, Mr. Downey, to expand Medicare benefits for psychiatric services and to support research in mental illness and its treatment. They have been a major factor in getting a process going to destigmatize mental illnesses and their treatments. The process has a lot further to go, but it is a very positive thing to see Congress taking an interest in this long neglected problem.

As my colleagues have already described, there is a very high prevalence of mental problems and behavioral problems in patients who reside in nursing homes. This problem is a heterogenous problem. Part of it consists of people who have been in the public mental health system, people with major—and in some cases, lifelong mental illnesses—who have wound up in nursing homes as they become old and physically frail.

However, there are other populations as well. There are those who have been mentally well all their lives, who develop Alzheimer's disease or related disorder, and then like one-third or more of patients with Alzheimer's disease go on to develop either paranoia, psychosis, major depression, agitated behavior, or a similar serious mental complication. That's another group. Those are people who never had anything to do with the public mental health system and then become ill with Alzheimer's disease or a related disorder and need intervention for mental and behavioral problems.

Then, you have people who have a physical illness or disability that lands them in the nursing home who become depressed, or anxious, or bereaved, either over the loss of their former health status or because an important family member has died. In other words, you've got emotional problems, you've got chronic mental illnesses, and you've got Alzheimer's and related disorders.

Now, one of the problems in this field is that when the agenda is to stigmatize, or deny services or funds, to this group, one simply tries to fragment the problem and divide the interests. So advocates for patients with Alzheimer's and related disorders, in an effort to destigmatize Alzheimer's disease, say that's not a mental illness.

But the truth of it is Alzheimer's patients get depressed, they get paranoid, they have agitated behavior, and they are given psychotropic drugs. So they have certain common interests with the chronically mentally ill and with the people who have a primary physical disability and then become depressed or anxious in reaction to the circumstances of their lives.

Now, mental illness in nursing homes, whether we're talking about chronic mentally ill patients who wind up in nursing homes when they become old and frail, or whether that we're talking

about people who develop mental problems for the first time later in life, is drastically undertreated, or mistreated.

I think that the evidence shows that people in nursing homes don't get specialist consultation, whether from psychiatrists or other mental health professionals, and they don't get specialized behavioral treatment. When they get drug therapy, the drug therapy is prescribed on the whole by nonspecialists and tends to be very nonspecific. When patients are agitated, they get something to make them settle down. They don't get an inquiry into why they are agitated, what the diagnosis is or what the circumstances are that cause them to act up.

If people have difficulty sleeping at night, what usually happens is they are given something to make them sleep, which may have the consequence of making them sleep all day as well, rather than a diagnosis as to why they cannot sleep.

So there's an absence on the whole of really thoughtful and comprehensive diagnosis of these problems. Comprehensive diagnosis has both a medical and a social and behavioral dimension. The medical aspect is absolutely essential. Many of the problems of people in nursing homes are caused or aggravated by side effects on the nervous system of drugs prescribed for medical reasons. Sometimes neurologic disease is responsible for abnormal behavior. But at the same time, the circumstances of a person's life and are also important. In the proper care of these patients there has to be an integration of medical and sociobehavioral perspectives, and without that, you're looking at one-half of the problem.

As distressed as I am by seeing overmedicated patients in nursing homes, there are also some patients with problems that absolutely need to be treated with medication and are not going to get better without it. So I don't feel that we're going to manage everything with behavioral therapy and more nursing assistants. That alone will not do it. By the same token, there are patients for whom drug therapy is absolutely inappropriate and without the provision of the nursing and social work services, and psychological assessment, they're not going to get what they need. Both are needed. The integration of the medical and sociobehavioral perspectives needs to happen, and doesn't happen.

Now, what are the reasons for this problem?

To begin with, there is an insufficient number of providers. Whether you look at the geriatric specialty, the psychiatric specialty, or the other mental health disciplines, there are not enough people in any of them who are dedicated to the care of the elderly.

I can talk about my own profession. There are between 35,000 and 40,000 psychiatrists, of whom about 1,000 belong to a subspecialty organization for geriatric psychiatry, and another 3,000 who devote a large segment of their practice to the care of the elderly. A total of 4,000.

And then there are additional psychiatrists who have a relatively smaller portion of their practice devoted to elderly people.

Four thousand people, for a country this size, with expertise in geriatric psychiatry—clearly not enough.

In psychology and social work the proportion of people with a primary focus on geriatrics also is far less than the wide prevalence of these problems would seem to indicate is necessary.

The providers who are there are often working in public sector or academic settings, or nonprofit settings of various kinds, because in general, reimbursement for mental health providers of all disciplines is inadequate. There are many financial disincentives.

In the case of psychologists and social workers, they are denied vendorship by Medicare. And in the case of psychiatrists, there's a discriminatory copayment and annual limit. And in many States, there are unrealistically low customary payment rates, which basically mean that a psychiatrist has to take a big financial hit to provide service in a nursing home. That would apply to psychologists and social workers as well.

Without an outside subsidy—whether from an academic institution or from a public sector program, the average private practitioner in any of the mental health disciplines has many financial disincentives from getting involved in treating the elderly and going into nursing homes.

Furthermore, there are regulations in nursing homes which discourage the diagnosis of mental disorders. Although these regulations may have been set up at one point to prevent State mental health systems from dumping patients inappropriately into nursing homes, the fact is the major wave of deinstitutionalization is over. The bulk of the mentally ill patients in nursing homes are not deinstitutionalized mental patients. Further, former mental patients are no less an important group that deserves more than they're getting, not less.

There are a lot of people in nursing homes who become mentally ill, depressed, demented, agitated, because they're physically ill, they're sick, or they're on drugs that affect their central nervous system—they have developed mental problems occurring for the first time in old age.

Now, these people, if they get a diagnosis of a mental disorder, it's nothing but regulatory trouble for that nursing home. They've got to worry about preadmission screening; they've got to worry about being reclassified as an institution for mental disorders, and they have to worry about all the other regulatory provisions, which although they were intended to improve quality of care for nursing home residents, in fact, say to those nursing home operator loud and clear: Don't take a patient who's got any mental or behavioral problems. And if you do, don't diagnose them.

Once the person is diagnosed there are many disincentives to treatment. First of all, there are disincentives to providers because they're not paid adequately, and in some cases, not at all, for the services they provide.

The nursing homes also have a limited consultation budget for outside consultants, most of which goes for things like help with respirators and feeding tubes, and there's not much left over to hire people that come in and help with behavioral programs, and train staff, and things like that.

If a nursing home receives a fixed Medicaid rate for all patients, and the patient with the behavioral problem requires a lot more time, a lot more attention, a lot more nursing staff involvement, so if you take a patient who doesn't have those behavioral problems, the cost of treating the patient is less and you do better financially.

Under a fixed Medicaid rate there is an incentive to avoid patients with behavorial problems.

In fact, a study in Massachusetts about who had to wait in a hospital the longest to get a nursing home bed showed that it was the patient who is covered by Medicaid and who has any kind of mental or behavioral problem. Those people often are sitting in acute care hospitals for 90, 120 days with the meter running at several hundred dollars a day in Federal Medicare money, because nursing homes have such potent disincentives not to take and treat people with mental illnesses.

Finally, there are some problems with the research knowledge base. Most research on psychotropic drugs is funded by drug companies, who on the whole, do studies on healthy, young people. So for all the zillions of studies on how to treat schizophrenia or depression in healthy, young people, we have very few studies which actually enable us to choose the safest and the most effective drugs and dosages for the treatment of elderly people who are physically sick, and frail, and have multiple problems.

So when the nursing home primary care physician is going to prescribe something for a patient's depression or sleep disorder, he gets barraged by the drug company detail men who tell him about drugs which very often have never really been systematically investigated in elderly people who are physically sick.

So there's a tremendous knowledge need, to develop and investigate the use of drugs for the treatment of common behavioral problems in elderly people, that are relatively safer for people who do have physical frailty and other impairments of advanced age.

Now, one final thing I want to mention here before going into solutions is the notion of the public sector's involvement, or the involvement of multidisciplinary teams, and so on. There are a lot of very inspiring demonstration projects; some of the ones that Dr. Baldwin's been involved in, other ones that have been carried out in other communities, funded by major foundations.

In any demonstration project, that has attempted the comprehensive care of older people, it is concluded that mental health problems emerge as being significant. And often they find that the resources budgeted for mental health—human resources as well financial resources—turn out to be less adequate than they thought, because needs are always underestimated.

Mental health problems are a major source of variability in who can cope with a physical illness. If you've got a physical illness, and you also have a mental problem, your chances of winding up in a nursing home are a lot greater.

Demonstration projects are not going to be the solution because demonstration projects draw on a limited number of dedicated people in areas where you have researchers and program developers. Any solution that's going to deal with this problem has to work in rural areas, it has to work in inner cities, and it has to work in places where there's no research university around—it has to be systematic.

Therefore, what are some suggestions for remedying this problem?

Certainly, there needs to be a Federal commitment to the support of training of providers of the mental health disciplines in

geriatric care; not only to train subspecialists, but also perhaps to see also that generalist providers—whether they be in psychiatric nursing, social work, psychology, or psychiatry—have some geriatric exposure.

At our institution—Brown University—where I am Associate Director of the Gerontology and Health Care Research Center and Director of Geriatric Psychiatry, we make sure that every psychiatry resident treats elderly patients—every one of them goes to a nursing home, every one of them sees chronically mentally ill elderly patients with physical illnesses. So they get desensitized and they get some hands-on experience.

And as a consequence, we don't have residents who on the whole shun elderly people. Many of them will actually seek out elderly people and take them on in treatment because that's been an integral part of their training. And I think that's something that should be done in a more general way. Notification of the Medicare direct or indirect payment schemes for medical education, as well as special programs, can create incentives to do that, to expose psychiatrists and other mental health providers in training to the elderly.

The reimbursement of provided is atrocious. I feel that, first of all, discriminatory copayments are in effect shutting people out from care. For the person who's poor and has limited resources, to ask them to pay 50 percent of the psychiatrist's fee is basically to say they're not going to get treatment. It's just not okay.

And if we want to have psychiatrists and other mental health professionals in nursing homes, we have to pay them a reasonable rate for what they do, we have to keep copaymentds low enough so that they don't become major deterrents of people getting care.

Regarding the involvement of other mental health professionals and the involvement of multidisciplinary teams, I'm in favor of anything that promotes access to care since access is so dismal right now. However, an essential part of evaluating and treating mental illness in nursing homes is somebody putting together the mental and the medical parts of the problem. Some integrative effort must take place.

A wonderful psychological or social work consultation completely disconnected from the prescribing physician will not work. Someone needs to integrate those medical and behavioral perspectives.

My own experience has taught me that psychiatric training is very helpful in doing that, and I believe that psychiatrists as a group may be the best qualified to perform that act of integration; but whether it's done by a psychiatrist or by someone else, it's got to be done. An add-on piece of care provided by a nurse or a social worker or a psychologist will do something, but if it's not integrated with going over that drug list and checking for sensory impairments and neurologic findings, it may not work.

Now, as far as regulations are concerned, I think the IMD provisions and various other provisions which discourage nursing homes from diagnosing mental illness are not helpful. And while there ought to be ways of preventing cost shifting and inappropriate dumping of patients, I think that discouraging the diagnosis of mental illness in elderly nursing home patients is not the way to do it. If anything, we should encourage diagnose to be made.

Regarding the funding of nursing homes themselves—nursing homes should be offered positive financial incentives to take on mentally ill elderly patients and offer them real treatment.

Now, if we are talking about some kind of case-mixed based reimbursement, that had better consider mental and behavioral problems as part of the formula, not just physical impairments, or else it will create new disincentives for nursing homes to deal with these problems.

Much care in nursing homes, as elsewhere, is reimbursement-driven, and the nursing home sector is largely proprietary. If we pay people to take care of elderly people with mental illness and to do it properly, they will do it. If they're not paid to do it or in fact are penalized for doing it, they won't do it.

Regarding research, I feel that in addition to the research agenda laid out already by others, there are two major areas that I think deserve attention. One of them is the development of better drug therapies for the common behavioral and mental problems of older people, specifically sleep disturbances, agitation, and depression. We cannot leave it to the random vagaries of the drug industry to determine who and what gets studied.

We need to study new drugs in elderly people and we need to study drugs for elderly people with combined physical and mental problems so that we can really enable our primary care doctors to choose drugs that have a chance of working and that are less likely to cause severe side-effects. Drug surveys in nursing homes have shown that very often drugs are prescribed by primary care doctors that are more toxic or more dangerous than they need to be. There are less toxic alternatives available that they could use if they knew about them.

So we have a research agenda and then we need to get that research out to the primary care doctors who are doing most of the prescribing. These psychotropic drugs aren't prescribed by psychiatrists or mental health professionals. They are prescribed by primary care doctors who often have very minimal training in psychiatric diagnosis and treatment.

The second piece of the research agenda is to look at the issue of cost savings, cost-offset effects. There's this notion that, yes, it would be lovely to serve this population but we don't have the money to do it because we have a budget deficit and all that.

I don't think you save money necessarily when older people are overmedicated and wind up with bedsores and wind up falling down and breaking their hips and requiring screws in their hips and another couple of weeks in an acute care hospital—and those things happen. Inappropriate treatment of mental health problems has consequences.

Further, it has the consequence that when you have assaultive patients, you have staff shortages, which drives up the cost of hiring nursing staff.

I'm not sure we save money by neglecting these problems. And I think that appropriate health services research might show that addressing certain kinds of mental health problems more systematically will maybe save money, and at least save as much as it costs while doing a lot to provide more humane and decent care to elderly people in nursing homes.

So I think there is a great deal that can be done that doesn't necessarily cost huge sums either, and I think that there's a moral imperative to do it.

I see Congresswoman Schneider here. I'd like to express my appreciation to you, also, for your steadfast support of services both for the mentally ill and for the elderly.

Thank you very much, Mr. Chairman.

[The prepared statement and supplemental material submitted by Dr. Fogel follows:]

American Psychiatric Association

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TESTIMONY

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

BEFORE THE

HOUSE SELECT COMMITTEE ON AGING
AND THE
HUMAN SERVICES SUBCOMMITTEE

ON

"MENTAL HEALTH AND NURSING HOMES: BARRIERS AND SOLUTIONS"

PRESENTED BY

BARRY FOGEL, M.D., CHAIRMAN
CORRESPONDING TASK FORCE ON GERIATRIC PSYCHIATRY IN THE PUBLIC MENTAL HEALTH SECTOR, AMERICAN PSYCHIATRIC ASSOCIATION COUNCIL ON AGING

AUGUST 3, 1989

Mr. Chairman, I am Barry Fogel M.D., chairman of the American Psychiatric Association's Corresponding Task Force on Geriatric Psychiatry in the Public Mental Health Sector and Legislative Representative for the Rhode Island Psychiatric Society. At Brown University, I am Director of the Division of Geriatric Psychiatry in the Department of Psychiatry and Human Behavior, and Associate Director of the University's Center for Gerontology and Health Care Research. As a geriatric psychiatrist, much of my own work has been devoted to research on treatment alternatives for the elderly mentally ill and on the financing of care for elderly people with neuropsychiatric disorders.

I appear today on behalf of the American Psychiatric Association, a medical specialty society representing more than 36,000 psychiatrists nationwide. I am pleased to present testimony on "Mental Health and Nursing Homes: Barriers and Solutions".

The APA has had a longstanding commitment to the treatment of patients with mental disorders and has, in fact, recently approved a subspecialty of geriatric psychiatry—the first such approval of a new subspecialty in 22 years. The American Board of Medical Specialties is expected to approve this change in September and it has already been approved by the American Board of Psychiatry and Neurology. Board examinations for added qualifications in this area are likely to be developed by 1991. APA's Board of Trustees has also recently approved publication of a Task Force Report on Nursing Homes and The Mentally

Ill Elderly. When the document has been published in the late Fall, APA would like to share it with the Aging Committee.

Before I begin, the APA would like to thank both the Chairman of the full Committee, Representative Roybal, and the Chairman of the Subcommittee, Representative Downey, for all of the work you have done to improve the Medicare benefit for patients with mental disorders, to increase funding for research on mental and addictive disorders, and to improve funding for training in geriatrics and mental health. Without your efforts and the efforts of members of this Committee, these important changes for our patients would not have been made.

My testimony today will focus on current problems associated with treatment of patients with mental disorders in nursing homes and offer suggestions for future methods of addressing these issues. The testimony initially reviews the scope of the problem; issues related to the nursing home reform legislation included in OBRA 87; and the role of the psychiatrist and specific psychiatric interventions in nursing homes. Woven throughout the testimony are concerns about the financing of care for our patients--often a barrier to care. Suggestions and policy recommendations are also included.

SCOPE OF THE PROBLEM

As this Committee well knows, the elderly population is growing and will represent a larger proportion of the population in future years.

Most of our elderly citizens have more than one health problem and may need more than one type of health care provider. Estimates indicate that some 15-20 percent, between 3 and 5 million, of our nation's older citizens have signifcant mental health problems. Moreover, in 1982 those persons over age 65 accounted for just over 10% of the U.S. population, but 17 percent of the deaths by suicide. According to the Institute of Medicine report on Improving the Quality of Care in Nursing Homes, 50-60 percent of nursing home residents have some type of mental or behavioral problem. Of the 1.3 million nursing home residents in 1977, 668,000 were classified as chronically mentally ill. Of that population, 72,000 were purely mentally ill, 35,000 had physical and mental disorders, and 561,000 were labelled as having senile dementia. These latter patients, predominantly suffering from Alzheimer's disease, suffer from depression or psychosis in more than one-third of the cases. Close to three-fourths have other physical disorders in addition to their dementing illness. Other studies have shown equivalent or higher rates of mental disorders in nursing homes. Data from a 1979 prevalence study in New York indicated that 45 percent of 200,000 patients in New York Skilled Nursing Facilities had clinically significant disorders of mood or behavior for which psychiatric referral was warranted. In a 1980 study of 60 nursing homes, over half of the patients received psychoactive medications, but fewer than 10% had a recorded diagnosis justifying medication use, and virtually none had seen a psychiatrist. Another 1980 study of 173 nursing homes demonstrated that 43 percent of the population had a

prescription for neuroleptic drugs. The average dose per patient correlated with the size of the nursing home and the size of the physician's caseload, suggesting that factors other than the patient's diagnosis affected physicians' decisions to prescribe. The patient receiving these neuroleptics practically never had psychiatric or psychological consultations.

Depression of clinical severity afflicts more than 30% of nursing home patients, even when one limits consideration to only those patients with physical illness as their reason for nursing home placement. Among some diagnostic groups, such as stroke patients, the rate of depression is even higher.

When psychotropic drugs are prescribed in nursing homes, there usually is no mental illness diagnosis, no comprehensive treatment plan, and no consultation with a psychiatrist or other mental health professional. There are several reasons for this discrepancy. First, nursing home operators are discouraged from recording mental illness diagnoses, lest their institution be reclassified as a mental institution and be ruled ineligible to receive Medicaid payments. Second, Medicare and Medicaid reimbursement for psychiatric services in nursing homes is inadequate to attract sufficient numbers of psychiatrists to work in nursing homes. Third, nursing home staff often lack the training to carry out sophisticated behavioral treatment plans. Finally, staffing levels in nursing homes often are too low for optimal behavioral management.

Many of the Federal policies that have the effect of discouraging mental disorder diagnoses and psychiatric treatment in nursing homes had their origin in a concern that nursing homes would become inappropriate placements for deinstitutionalized mental hospital patients. While some inappropriate placement of chronically mentally ill patients in nursing home remains a real problem, the problem of inappropriate or excessive medication of nursing home residents without histories of chronic mental illness is equally pressing. In my opinion, the best protection a patient has against inappropriate or excessive medication is a thoughtful diagnosis and a comprehensive, multidisciplinary treatment plan. Adequate diagnoses and treatment plans require acknowledging the high prevalence of mental and behavioral problems among residents of nursing homes, and ending discrimination against nursing home patients who do have mental as well as physical disorders.

The patient whose stroke is complicated by a post-stroke depression deserves comprehensive care that addresses his/her mood as well as his/her neurologic deficits. In fact, treatment of the depression may actually improve physical functioning and increase the likelihood of discharge back to the community. It is tragic that Medicare places financial barriers between that patient and appropriate treatment, and that Medicaid regulations discourage the diagnosis of depression from being made. Recent data from a chain of 55 nursing homes illustrate this point: less than 3% of nursing home patients with strokes receive

an additional diagnosis of depression, and less than 5% receive treatment for depression. This is true even though the prevalence of post-stroke depression has been shown to be 50% or higher.

In discussions of mental disorders and psychotropic drugs in nursing homes, it may be helpful to distinguish between patients with mental disorders as reasons for nursing home admission and patients with mental disorders as complications or concomitants of physical illnesses and disabilities that require nursing home care. The former group usually has received some kind of mental health care, whereas the latter usually has not. The person who develops a depression for the first time following a stroke, or who becomes paranoid as a complication of Alzheimer's disease, is not accustomed to consulting psychiatrists or visiting mental health centers. Instead these patients rely on their primary care physicians, and on nursing home staff, to facilitate their access to appropriate psychiatric care. Both regulatory and reimbursement policy should make this easier, not harder.

The widespread use of psychotropic drugs in nursing homes has often been interpreted as evidence of overmedication or drug misuse. I think it is better understood as the consequence of well-intentioned, but imperfect, efforts by nursing home physicians and staff to address the highly prevalent mental, emotional, and behavioral problems that afflict nursing home residents. What nursing home residents need is a

comprehensive evaluation of their mental and behavioral problems, that includes a medical differential diagnosis, consideration of nonpharmacologic therapies, and thoughtful and specific use of psychotropic drugs in appropriate dosage and with close and continual monitoring. One patient might require a behavioral management program and no medication, another might need a psychotoxic drug to be discontinued, a third might benefit from psychotherapy, and a fourth might need a higher dose of a psychotropic medication than he/she had been receiving. Only with proper diagnosis and comprehensive treatment planning can nursing home residents be assured adequate treatment and freedom from excessive or inappropriate treatment.

Financing of care for patients with mental disorders contributes to the problems associated with delivery of care. Until recently, the Medicare outpatient benefit for patients with mental disorders was restricted to a net $250 per annum per beneficiary. In OBRA 87 this benefit was expanded so that Medicare pays up to $1,100. However, the beneficiary is responsible for an effective 50 percent copayment and, in many regions, Medicare allows substantially less than full-market fees for treatment, often leading to even greater patient liability. Certain outpatient services such as diagnosis and changing and monitoring of drugs are exempt from this limitation; patients are responsible for a 20 percent copayment for these services. All medical management services for patients with Alzheimer's disease and related disorders are exempt from the dollar limitation and the patient

is responsible for a 20 percent copayment. Since physicians' services under Medicare in a nursing home are paid as an outpatient service, financial constraints have led to limited access to psychiatrists' services in nursing homes. Representative Roybal's Mental Health and Aging Act has clearly attempted to redress many of these issues. Recently, both the House Energy and Commerce and House Ways and Means Committees approved, at the Committee level, elimination of the Medicare outpatient mental health dollar limitation, although the copayment for most of care is still prohibitively high for many beneficiaries.

Other difficulties exist with the Medicaid program. Many nursing homes cannot provide appropriate care for patients with mental disorders or they will lose their nursing home classification and be reclassified as an Institution for Mental Diseases (IMD). Under current interpretation of HCFA regulations, individuals with organic mental disorders are not counted toward the percentage that defines an IMD (more than 50 percent of patients with mental disorders). Needless to say, variable, often exceedingly low, reimbursement for providers has often resulted in low provider participation rates.

The science of understanding, diagnosing and treating mental illnesses has changed significantly during the decades since Medicare and Medicaid were enacted. Arbitrary and discriminatory prohibitions on treatment of patients with primary and secondary mental disorders in

nursing homes still exist. Hopefully, the Aging Committee will work with others in Congress to address these changes.

OBRA 87- NURSING HOME REFORM PROVISIONS

APA appreciates the significant contributions that both the IOM and the Congress have made in addressing nursing home reform. For the record, we are enclosing APA's comments on the final regulations on "Medicare and Medicaid; Requirements for Long Term Care Facilities" published February 2, 1989 in the Federal Register (Attachment A). APA has worked closely with the Health Care Financing Administration to make certain that the screening criteria used for patients with mental disorders are appropriate and sufficiently protect beneficiaries.

MODEL PROGRAMS IN NURSING HOMES

The literature describes a number of models of nursing home provision of psychiatric services. Some of the models were developed in response to concerns about transfer of patients from state mental hospitals into nursing homes. Many of the programs have been established through the use of salaried physicians at community mental health centers. Many of the programs funded through community mental health centers (CMHCs)were disbanded when the direct Federal grant program was replaced by block grants to the states. Some states did fund these programs at former capacity and others reduced service delivery. Individual psychiatrists

have also established relationships with nursing homes and visit on a weekly or monthly basis to see patients.

THE ROLE OF THE PSYCHIATRIST IN NURSING HOMES

Psychiatrists have through their training and education acquired special expertise and training in the medical assessment and medical differential diagnosis of emotional, behavioral, and cognitive problems associated with both the aging process, in general, and with physical and mental disorders in the aged population. In the nursing home setting, the psychiatrist can work in a consultative capacity with the nursing home staff to assist in the design of therapeutic programs and environments; provide in-service training and education to assist staff in assessing and managing patients; provide medical differential diagnoses and treatment plans; and prescribe and provide pharmacologic and psychosocial interventions to manage nursing home patients.

The nursing home patient often presents a complicated array of problems. Careful assessment by the psychiatrist or other physicians of cognitive impairment, physical problems and associated medical reactions, and behavioral symptoms is necessary to determine the etiology of a disorder. Agitated behavior is often the most likely symptom causing a referral for psychiatric treatment. Agitation may be present due to several different mental disorders (both chronic and acute). This undifferentiated symptom is one of the ones requiring

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extensive evaluation of the etiology of the agitation. Treatment often includes neuroleptic drugs. Careful evaluation and management of patients' responses to these drugs is essential, as these pharmacologic interventions have significant side-effects and are not always effective.

Mental disorders in nursing homes can be managed through pharmacologic, behavioral and psychotherapeutic interventions. Prescription of psychotropic drugs to nursing home patients is a complicated medical intervention and requires special attention because these patients are older, usually frail, and have multiple medical problems. Unfortunately few nursing homes consult with psychiatrists on the appropriateness of psychotropic drug use, and evidence exists that psychotropic drugs frequently are overprescribed or misused by nonpsychiatric physicians. Psychotropic drug use should be part of an extensive plan of comprehensive care. A psychiatric consultant, whether working individually or as head or part of a team, is properly trained to assess the risks and benefits of medication, taking individual differences into account. The presentation of multiple interactive physical and mental disorders necessitates that a physician head the team defining and implementing care plans.

Certain behaviors in nursing homes are most appropriately treated through behavioral interventions after an appropriate plan of care has been established. For instance, wandering behavior usually can best

be managed by establishing an appropriate schedule of activities and modifying the environment.

Psychotherapeutic interventions in nursing homes have often been limited, both due to limited Medicare coverage and due to the pre-emptive needs of nursing home staff for assistance with severe behavioral problems. Nonetheless, many patients could benefit from short term psychotherapy in the nursing home. Psychotherapy may be particularly helpful to patients who have just been placed in a nursing home, and have difficulties adjusting to their change in circumstances. Nursing home residents grieving the loss of a friend or family member also may benefit from psychotherapy.

There has been much discussion of multi-disciplinary teams in the assessment and management of behavioral problems among frail, elderly patients. I directed such a multi-disciplinary team for eight years. To me, the essential ingredient in a successful team approach is integration by the physician of the medical and nonmedical dimensions of the problems. Psychiatrists, because they have medical training and extensive experience in working with other disciplines including nursing, social work and psychology, may be particularly well-suited to perform this task of integration.

SUGGESTIONS FOR THE FUTURE

Nursing homes have received considerable attention from policy makers

in recent years, but there are a number of areas that still need to be addressed. First, more data needs to be collected on the extent and types of behavioral and emotional disturbance prevalent in nursing homes, using rigorous, modern diagnostic methodology. This could be done through the National Institute of Mental Health and the National Nursing Home survey. Specific studies are needed on which particular psychiatric and other mental health interventions are most useful in nursing home settings. Research specifically focusing on the application of psychopharmacologic agents to major psychiatric problems of frail elderly patients is also needed. Needs include: 1) alternatives to major tranquilizers for the treatment of agitation in Alzheimer's disease; 2) safe and effective treatments for sleep-wake disturbances in chronically ill patients; and 3) antidepressants that are safe for extremely frail elderly persons.

Consideration should be given to raising effective reimbursement rates for medical services in nursing homes in order to further encourage physicians, including psychiatrists, to see more nursing home patients. The copayment for psychiatric services should be reduced or eliminated if the services are rendered in nursing homes. Additional funding for training should be provided for geriatric psychiatry in order to expand the cadre of psychiatrists with specific training in geriatrics. In addition, Medicaid regulations should establish nursing homes for patients with combined physical and mental illnesses, and Medicaid rates should appropriately provide the extra care that patients with behavioral problems require.

SUMMARY

Psychotropic drugs are widely prescribed in nursing homes, often without a mental disorder diagnosis, and usually without either specialist consultation or a comprehensive treatment plan. While various mental disorders are highly prevalent in nursing homes, regulations paradoxically discourage their diagnosis, and reimbursement practices discourage specialist consultation. The consequence is the treatment of mental and behavioral symptoms with psychotropic drugs alone, rather than with a comprehensive and holistic approach. Furthermore, primary care physicians in nursing homes often choose psychotropic drugs and dosages without regard to the knowledge base of modern geriatric psychopharmacology, with the consequences of side effects that could have been avoided, and of less satisfactory clinical outcomes. Federal regulatory and reimbursement policies should be modified to facilitate accurate diagnosis and comprehensive treatment of mental disorders in nursing home residents. Federally-supported research should address epidemiological and service delivery issues related to mental disorders in nursing homes. Research should also promote the development of safer and more effective treatments for common behavioral problems of the frail and physically ill elderly, including agitation, depression, and sleep-wake disturbances.

Patients in nursing homes present a complicated array of problems. Often their physical disorders interact with or produce their medical

disorders. Prescription and nonprescription medications may also produce behavioral or mental illness symptoms. Geriatric psychiatrists can play a unique role with this population, and nursing homes might be required to consult with psychiatrists about their patients.

Attachment

ATTACHMENT A

American Psychiatric Association

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May 3, 1989

Louis Hays
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, MD 21207

Attention: BERC-396-FC

Dear Administrator Hays:

The American Psychiatric Association, a medical specialty society representing over 35,000 psychiatrists nationwide, takes this opportunity to submit written comments on the final regulations entitled "Medicare and Medicaid; Requirements for Long Term Care Facilities" published February 2, 1989 in the Federal Register at page 5316. These final regulations incorporate many of the recommendations for nursing home reform contained in the Institute of Medicine's 1986 report on Improving the Quality of Care in Nursing Homes and, as well, significant Medicare and Medicaid statutory changes pursuant to the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), P.L. 100-203.

General Comments

We appreciate the significant contributions that the IOM and Congress have made in addressing nursing home reform and the time, effort and energy expended by HCFA staff in developing implementing regulations and instructions on the many aspects of the care and treatment of individuals in the nursing home setting. The APA has welcomed the many opportunities HCFA has offered us (as it has to other physician, provider and patient organizations) to provide our clinical and policy input at various stages of regulatory and interpretive guideline development. We plan to continue our constructive efforts to assure that nursing home patients receive appropriate treatment services, and particularly services for the diagnosis and effective treatment of mental disorders.

As you are undoubtedly aware, studies have documented that substantial numbers of individuals in nursing homes suffer from a

mental disorder. Unfortunately, evidence also indicates that psychiatric problems are frequently undiagnosed or misdiagnosed and left untreated. Clearly, the critical importance of accurately diagnosing and effectively treating this population cannot be overstated.

In the near future, the APA's Task Force on Nursing Homes and the Mentally Ill Elderly will be releasing its report on nursing homes and the elderly. This report, supported in part through a contract with the National Institute of Mental Health, presents in detail the role of the psychiatrist in caring for patients with mental disorders in nursing homes, details current psychiatric care approaches to this population, and offers a series of recommendations to existing problems. Upon completion, the APA would be pleased to send this significant report to you.

Without question, the APA views the OBRA 1987 provisions as reflecting Congressional concern that patients in nursing homes receive appropriate nursing home care for their physical and mental illnesses; that patients are not simply warehoused in nursing homes. Thus, our two dominant concerns with regulatory implementation reflect first, that patients receive appropriate and necessary psychiatric care, and second, statutory and regulatory provisions for screening patients with mental illness or mental retardation do not by this very process exclude such patients as a class from the nursing home setting.

Thus, the APA has a very strong interest in the promulgation and implementation of these final regulations. In our view, the regulations can be revised to better meet both our concerns. Finally, the issue of adequate federal financial support of services provided in nursing homes through Medicaid or other federal programs has not been resolved satisfactorily. Until Congress provides additional support, patient access to care and the quality of that care in the nursing home remains at risk.

Conformance to Statutory Requirements

The final regulations do not accurately represent the Medicaid statute's requirements for the provision of services for those patients suffering from a mental disorder. Section 1919(b)(2) of the Social Security Act states that a nursing facility participating in Medicaid "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." Further, Section 1919 (b)(4)(i),(ii) requires the nursing facility to provide or arrange for "nursing and related services and specialized rehabilitation services" and

"medically-related social services" to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." Subsection (b)(4)(iv) also requires "an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident."

These statutory requirements are clear and significant. These are affirmative obligations nursing homes must meet in order to be in compliance and participate in Medicaid. While we understand that HCFA will be publishing separately proposed regulations on various other aspects of nursing home reform mandated under OBRA 87, our review of these final regulations fails to reveal sufficient regulatory language implementing the above noted statutory provisions.

We would offer the following specific revisions to the regulations to bring them into conformance to statutory requirements for services to residents with diagnoses of mental illness so that the statutory provisions can be appropriately implemented.

Resident rights, codified in section 483.10, should be amended to include a statement that the resident has the right to treatment for all mental and physical conditions identified and in accordance with the resident's comprehensive assessment and plan of care. This elevates the resident's right to treatment as a level A requirement and makes it consistent with section 483.20 that requires comprehensive assessments and section 483.25 quality of care requirements. Since this 483.10 also specifies that a resident may refuse treatment, it should also obviously include the corollary right to receive treatment.

In addition, we request clarification of subsection 483.10 (b)(4) regarding the resident's right to refuse treatment. First, where residents have been adjudged incompetent under State law by a court of competent jurisdiction, as noted in subsection (a)(3), applicable state law oftentimes determines how the right to refuse treatment is carried out. We are appreciative of the effort that was made to discuss in the commentary the variability of state law on the right to refuse treatment issue. However, we question HCFA's ultimate solution to the consistent refusal of all treatment, discharge from the facility (page 5321, third column). One alternative HCFA may wish to incorporate into the regulations or subsequent interpretive instructions is that a petition for a court appointed guardian be considered.

Comprehensive assessments, codified in section 483.20 and specificially subsection (b)(2)(iii) should be amended by adding the phrase physical and mental before functional status, and in (vii) by adding mental and before psychosocial status. Clearly, a comprehensive assessment by definition should include assessment of the mental status of the resident in conformance to section 1919 (b)(2) of the Social Security Act as noted above. Since an assessment must be performed under subsection (b)(4)(iv) promptly after a significant change in the resident's mental or physical condition, it is necessary to have available baseline information on the mental status of the resident.

Specialized rehabilitative services, codified in section 483.45 should also be revised to include in that list psychiatric rehabilitation services. This action would permit conformance to section 1919 (b)(4) of the Social Security Act also noted above. The APA would be interested in working with HCFA to define the range and scope of such services.

Role of Physician

The APA specifically approves the retained requirement under section 483.75 (k) that the nursing facility designate a physician to serve as medical director who is responsible for implementation of resident care policies and the coordination of medical care in the facility. However, we must urge that the regulations section 483. 20 better emphasize the role of the physician in conducting the resident assessment and comprehensive plan of care. Specifically, the psychiatrist's role with regard to the diagnosis, treatment and plan of care for those with mental illness must be recognized both in the regulations and the interpretive guidelines.

Moreover, it is important to understand that the psychiatrist is uniquely trained to treat the patient who requires both pharmacotherapy and psychotherapy, an increasingly frequent therapeutic prescription in an era of advancing understanding of complex biopsychosocial components of mental illness. We know that psychiatric symptoms are frequently non-specific and commonly occur in a variety of physical illnesses. There is also evidence indicating that having a psychiatric diagnosis is associated with a high risk of physical illness. In addition, there are a great many physical illnesses that, upon initial presentation, appear to be mental disorders.

The research literature fully documents mental illness produced by infections, thyroid gland dysfunction, chronic encephalopathy related to heart block, Wilson's disease, carcinoma of the pancreas, hyper-parathyroidism, sub-acute encephalitis, strokes, as well as the psychiatric and neurologic impact of AIDS.

Thus, in the nursing home setting we believe additional changes are necessary to help assure that patients in need of psychiatric care are identified, accurately diagnosed and treated. While section 483.20 emphasizes the importance of the comprehensive nursing home assessment, we remain concerned that mental disorders will go undiagnosed or be misdiagnosed. Accordingly, we recommend that this section be revised (or in the alternative the interpretive guidelines) to require consultation with a psychiatrist in situations where a behavioral disturbance is present or where there is significant cognitive deterioration. For example, a psychiatrist is needed to render a differential diagnosis which would distinguish between a drug side effect, an underlying medical condition or a primary psychiatric disorder such as depression. Such consultation should be a requirement whenever these symptoms present themselves.

Finally, we are concerned in 483.40 about the possibility that the requirement of physician visits (initial and subsequent) could become a ceiling rather than floor. Physician involvement with nursing home patients is of paramount importance.

Pharmacologic Therapy

The APA has some significant concerns regarding both the commentary preceding the regulations section on drugs, 483.25 (1), and the specific language as written. First, the commentary on page 5333 strongly implies that an individual who is on long term antipsychotic medication is almost certainly in need of "active treatment". This is a misperception of the role of antipsychotics in the maintenance treatment of patients with chronic psychiatric illnesses. As in patients with other chronic illnesses, maintenance medications are required and do not constitute "active treatment". We assume the HCFA is not suggesting or implying that nursing home residents who receive insulin for diabetes mellitus, antihypertensives, or digitalis and diuretics for cardiac disease were in active treatment and inappropriate for nursing home care.

, we believe the commentary underscores a fundamental misunderstanding of antipsychotic drugs. By decreasing psychotic symptoms, these drugs can actually increase initiative, affect and interest in surroundings. Again, the discussion on page 5335 regarding unnecessary drugs states in part that "drug therapy extinguishes normal affect," when, in fact, such therapy may be essential to restore normal affect!

The language of section 483.25 (l) is an improvement over the earlier proposed condition, including subsection (2)(ii) that originally required residents who use antipsychotic drugs to receive gradual dose reductions, drug holidays, or behavioral programming. This subsection now recognizes that efforts to discontinue antipsychotic drug use may not be therapeutically appropriate for all patients, by including the phrase "unless clinically contraindicated in an effort to discontinue these drugs." We suggest, however, the phraseology "unless clinically contraindicated" sufficient as the remainder is unnecessary and potentially confusing.

Screening Requirements and Active Treatment

The nursing home prescreening requirements for the mentally ill and mentally retarded contained in Section 1919 (b)(3)(F) of the Social Security Act and codified in 483.20 (f) and effective January 1, 1989 remain very troubling to the APA. As stated in our introductory remarks, we continue to be deeply concerned that the required screening could result in the arbitrary exclusion of the mentally ill from the nursing homes on the basis of a diagnosis or an incorrect belief that treatment services provided by nursing homes will be considered "active treatment" and not be reimbursed under Medicaid.

Over the past year, the APA has cooperated with HCFA in the development of interpretive guidelines for the screening criteria. Those guidelines have just been disseminated to the states and will be subject to additional rulemaking. The critical issue of defining "active treatment" for purposes of the nursing home setting, that is where placement may be inappropriate, has hopefully been adequately addressed through the new screening criteria. We urge HCFA to publish proposed regulations on the screening criteria expeditiously to permit review and comment by all interested parties. Certainly the APA plans to comment on that upcoming proposed rule. In the interim, we will continue to monitor the application of the screening criteria by the states and the nursing homes so as to assure that our patients are not denied access and appropriate care. We recommend that HCFA also closely monitor the implementation of these criteria and act swiftly to prevent any discrimination against the mentally ill or the mentally retarded.

Conclusion

In closing, the APA hopes its comments are helpful in the review of these regulations and their republication in final form. As always, we would be pleased to work with HCFA to assure that appropriate standards are promulgated to protect our patients and provide them necessary services.

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director

QUESTIONS FOR DR. BARRY FOGEL M.D., REPRESENTATIVE OF THE AMERICAN PSYCHIATRIC ASSOCIATION

1. Within the United States, how many psychiatrists are currently specializing in the field of geriatrics?
   Since there are not enough psychiatrists to meet the current demand and it seems unlikely that the situation will change in the near future, what solutions do you see for the present?

2. Your testimony states that approximately 60 percent of nursing home residents have some type of mental disorder. Why is this rate so high, and why haven't nursing homes attempted to do something about this problem in the past?

3. On page 3 of your testimony, you state that "in a 1980 study of 60 nursing homes, over half of the patients received psychoactive medications, but fewer than 10% had a recorded diagnosis justifying medication use". Why was this allowed to happen?

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Center for Gerontology
and Health Care Research

Vincent Mor, Ph.D.

Barry Fogel, M.D.

August 29, 1989

The Honorable Edward R. Roybal, Chairman
U. S. House of Representatives
Select Committee on Aging
300 New Jersey Avenue SE, Room 712
Washington, DC 20515

Re: HR-111 and your letter of August 7th

Dear Congressman Roybal,

Thank you for the opportunity to comment on HR-111 and to further address the questions raised at the hearing earlier this month. Attached are two documents - one responding to your questions and the other offering comment on HR-111.

I hope you will find some of the suggestions helpful. I would be happy to talk about these issues in greater detail with members of your staff.

Sincerely,

Barry S. Fogel MD

Barry S. Fogel, M.D.

BSF:rs
Enclosures

Replies to Questions

1. Approximately 1,000 to 2,000 psychiatrists in the United States, or about 5% of all psychiatrists, specialize in geriatrics. Another group of psychiatrists, of about equal size, deals primarily with psychiatric problems in the medically ill; these psychiatrists have a substantial geriatric component to their practice.

Since there will not be enough specialists in geriatric psychiatry to render services to all elderly who might need them, improving access in the near term will require greater involvement of general psychiatrists in the care of the elderly. This could be facilitated by the following measures: a) improving Medicare reimbursement for psychiatric services to the elderly, particularly when provided in nursing homes and in general hospitals; b) requiring meaningful exposure to geriatric psychiatry for all psychiatry residents, as a condition for training programs receiving the Medicare graduate education subsidy. This could be supplemented by providing supplementary training monies to psychiatry residencies with particularly strong geriatric components, and by continuing direct medical education subsidies for fully-trained psychiatrists who pursued additional training in geriatric psychiatry; c) providing Federal support for intensive training programs in geriatric psychiatry for practicing psychiatrists, that would make it feasible for practicing psychiatrists to take the time to obtain advanced training in the care of the care of the elderly mentally ill.

2. The quoted rate of 60% for mental illness in nursing homes comes from including Alzheimer's disease and related

disorders in mental illnesses. If these are excluded, the rate of mental illness is about one-third. Either way, both persons with dementia and persons with other mental illnesses present problems in behavioral management, and suffer from psychological distress. Nursing home operators and professional staff have been doing their best to deal with this problem, but have been hampered by generally inadequate financial and human resources.

3. The administration of psychoactive medications to nursing home residents without mental disorder diagnoses is a consequence of the usual practice of non-psychiatric physicians in dealing with mental and behavioral complaints. Physicians in general practice, whether they treat outpatients or nursing home patients, tend to treat mental symptoms with medication without making a formal psychiatric diagnosis. Patients with insomnia receive sleeping pills; patients with agitation or paranoia receive major tranquilizers. Formal mental disorder diagnoses are rarely made for a number of reasons. First, not all non-psychiatric physicians are skilled in making psychiatric diagnoses. Second, because psychotropic drugs usually are used by these physicians to treat symptoms rather than diagnoses, a requirement that formal diagnoses be recorded would have an uncertain effect on quality of care. Third, in nursing homes, there are regulatory disincentives to making a mental disorder diagnosis.

In my opinion, much of the prescribing that goes on without recorded diagnoses may actually be appropriate and helpful to the patients. The problem is that without diagnoses, it is difficult to verify the appropriateness of prescriptions or to meaningfully track outcomes.

It is not clear that asking non-psychiatric physicians simply to write down diagnoses would actually improve quality of care, unless this were coupled with better training in psychiatry, and greater availability of mental health specialist consultation.

4. Poor Medicare and Medicaid reimbursement for psychiatric services in nursing homes is unequivocally a major reason for the relative lack of psychiatric involvement in nursing homes. Whether it is the major reason is difficult to say, because poorly reimbursed areas over time tend to get short shrift in training and research as well. A sustained improvement in reimbursement for psychiatric services in nursing homes would not only attract more psychiatrists to the area immediately, but also would stimulate training in the area, that would in turn improve the supply of qualified providers.

The problem at present is that Medicare and Medicaid rates in most communities are well below the fees that psychiatrists charge patients who pay out of pocket, or who are covered by private insurance. Thus, effectively, the psychiatrist treats Medicare and Medicaid patients at a substantial discount from his or her usual fee. When one adds to this travel time to the nursing home, the greater medical complexity of nursing home patients, and the time needed for coordinating care with the primary care physician and nursing home staff, the effective discount on the psychiatrist's usual hourly rate exceeds 50% in many cases. Furthermore, psychiatrists in private practice have in general not relied upon the elderly as a principal source of patients; in this respect they differ from internists. It is an option for most psychiatrists not to treat the elderly

at all, and many psychiatrists do avoid the elderly because payment is so unsatisfactory.

There are a number of remedies to this problem. The first is to "un-discount" the fees paid to psychiatrists who render psychiatric services in nursing homes. In other words, if the usual Medicare reimbursement for a psychiatric service is 20% below the prevalent community rate for that service, a supplement of 20% could be added to the Medicare reimbursement if the site of service were a nursing home. Second, regulations could make clear that time spent coordinating care with the resident's primary care doctor and with the nursing staff would be reimbursable, at an equal rate as time spent with the patient or family. This should include time spent over the telephone in care coordination activities. Third, Medicaid rates for psychiatric services in nursing homes should be set equal to Medicare reimbursement rates. Fourth, Medicare and Medicaid reimbursement to nursing facilities for institutional consultation should specifically earmark funds for psychiatric and psychological consultation to the institution, for staff training and development of management protocols for mental and behavioral problems. Psychiatrists who become involved in institutional consultation would be ideally placed to provide services to individual patients, and the two roles would be complementary.

5. Reducing the Medicare copayment for mental health services would not only motivate patients to seek mental health services, but also would motivate providers. When physicians provide services to elderly people of limited means, they rely upon the certainty of the Medicare payment,

as the patients' copayments may be uncertain or delayed, and most ethical physicians are reluctant to press sick patients of limited means to make copayments immediately and in full. Furthermore, if mental health treatment is provided on referral from a primary care physician (the usual situation), there may be a reluctance to refer patients for specialty mental health treatment if the primary care doctor feels this will saddle the patient or family with a large copayment. Thus, reducing the copayment may increase primary care doctors' willingness to refer patients for specialty mental health services, and will reduce the financial risk to the provider that the patient will be unable to make the copayment. Both of these effects should improve access.

Comments on HR-111

1. Regarding ADAMHA block grants, a potential problem of this bill is that it may fund services for the elderly at the expense of needed services for the non-elderly mentally ill. Much as I feel the elderly are under-served, I do not feel that improved services for the elderly should come at the expense of the younger mentally ill. For this reason, it might be reasonable to place an allocation requirement on new block grant dollars. For example, 50% of new block grant dollars could be allocated to services for the elderly, until the overall proportion reached the criterion specified in the current version of the bill.

2. HR-111 refers to individuals giving written informed consent for all treatments. In my opinion, this is impractical, and may impede patients' access to needed treatment. Patients who receive other forms of medical care do not give written consent unless the treatment is of particularly high risk or complexity, such as a surgical procedure. I think it is inappropriate and unnecessarily frightening to an elderly person to require written informed consent to such procedures as psychotherapy or the administration of a relatively non-toxic antidepressant drug.

In addition to potentially frightening and discouraging some patients from treatment, the requirement of written informed consent creates an administrative burden, taking time that might be better spent offering direct diagnosis and treatment, and creates numerous situations of legal complexity. At worst, it may actually cause patients to get more restrictive treatment than necessary. For example, a

mildly paranoid elderly person might be willing to take medication to treat his paranoid thinking, but might be afraid to sign an informed consent document. In the absence of treatment, the paranoid thinking might escalate to the point where hospitalization would be necessary.

A requirement of informed consent, without specifying that it is written, would leave the type of consent as a matter of clinician judgment. If the word "written" should be removed, the remainder of the provision would be unexceptionable.

3. On page 18 of the bill, a reduction in the co-insurance rate for Medicare is linked to a cap on the number of visits per year, with a provision for extension in the case of medical necessity. The language of this paragraph could be strengthened to make clear that patients with a clear medical necessity for more extensive outpatient treatment should receive reimbursement. Given the propensity of HCFA to interpret Congressional language in a way that will save the most money, the language "may be extended" might be interpreted so narrowly that it will in practice be impossible to get extensions.

A specific concern is that when more frequent outpatient visits function to avert a costly hospitalization, it is clearly in the interest of the Medicare system to encourage the prompt approval of reimbursement for such outpatient care. The bill should specify that a clearcut mechanism for approving extensions of coverage should be developed by HCFA, with a speedy prior approval mechanism that would enable intensive outpatient care to become a treatment option that could be substituted for inpatient treatment.

4. The redefinition of institutions for mental diseases is great!

5. Section 205 on Medicare cost containment should in my opinion be deleted. As we have pointed out, there are already significant financial disincentives for psychiatrists entering into the care of the elderly. Adding compulsory assignment and limits on charges that would not apply to physicians of other specialties or to other age groups works against the goal of encouraging psychiatrists to spend more of their time serving the elderly. While psychiatrists as a group have a high rate of accepting assignment, the APA is opposed to making assignment mandatory. If it is deemed that compulsory assignment is politically necessary to get this bill passed, my personal opinion is that it should be based on a means test, so that psychiatrists treating the elderly would not be forced to give large discounts to elderly patients who were willing and able to pay the market rate for services. The problem is particularly acute in psychiatry since reimbursement for psychiatric services by Medicare often is well below the actual community rate for those services.

Along similar lines, the requirement that reasonable charges may increase no faster than the CPI is somewhat ironic, since many states' Medicare reimbursement for psychiatric services has been increased at a rate <u>well below</u> the CPI, leading to a decline in the real incomes of psychiatrists concentrating their services on Medicare beneficiaries. Many of these psychiatrists would be delighted if the CPI were both the minimum and the maximum

for the rate of increase of Medicare payments to psychiatrists.

In addition to these specific comments, I believe the bill could be strengthened by incorporating some of the incentives for service and training in geriatric psychiatry discussed in the replies to your earlier questions.

Mr. ROYBAL. I recognize Ms. Schneider.

Ms. SCHNEIDER. Mr. Chairman, I realize that the bells have rung and we do have a vote coming up, but I did want to introduce to my colleagues Dr. Fogel—and I'm happy that I was able to make it here in time to hear most of his testimony. I came from my Research Committee, where we were having a markup, but I am grateful that Dr. Fogel has shared with my colleagues some of his concern about the need for additional research, his emphasis on training, the emphasis on reimbursement, and needless to say, access. All are high priorities.

I am very honored to have such an astute witness appear before this committee. I only hope that our committee can pick up on some of the initiatives that he has so well articulated.

Thank you.

Mr. ROYBAL. Thank you, Ms. Schneider.

It seems that we have a vote to cast on the Floor of the House and it becomes necessary for the committee to recess for 10 minutes.

The committee is now in recess.

[A short recess was taken.]

Mr. ROYBAL. I would like to apologize for the delay and have you know it was due to a roll call vote, or votes, in which there was an attempt to return to committee the House appropriation's bill. The reason for that was that it had an abortion item, a decision made by the House last night. The end result was that it was not recommitted and the bill, I think, will be passed in the next few minutes. I voted for the passing of the bill and I'm sure other members of this committee did.

The Chair now recognizes Mr. Mays.

STATEMENT OF WILLARD L. MAYS, M.A., DIRECTOR, OLDER ADULT SERVICES, DEPARTMENT OF MENTAL HEALTH, STATE OF INDIANA

Mr. MAYS. Mr. Chairman and members of the committee, thank you for inviting me here today. In addition to representing the State of Indiana, I am also representing the National Association of State Mental Health Program Directors, which represents the mental health authorities of 55 States and Territories. My colleagues, prior to myself, have already covered many of the issues that are included in my written testimony and I will try not to duplicate any of the information that they have provided.

I would like to focus on the State of Indiana as a kind of typical State and give you some information from surveys that we have taken. I would also like to address some of the barriers, many of which have already been mentioned and also have some comments on the OBRA '87 legislation that I would like to submit.

Our Indiana State Board of Health does an annual survey of nursing facilities and the most recent information available is for 1987. As of the end of 1987, we had approximately 45,000 nursing home residents in the State of Indiana. Of this group, 39,000, or 87 percent, were 65 years of age or over. Five percent of this nursing home population had a primary mental illness diagnosis.

I would like to support a comment that Dr. Fogel made a few moments ago about the fact that the majority of the mentally ill folks in nursing homes do not come from State hospitals. There is a perception that most of the people in nursing facilities were at some point in time "dumped out" from State mental institutions. Our statistics clearly do not bear this out. In fact, less than 50 percent of this 5 percent actually came out of State mental facilities.

A presurvey of the 1985 NIMH, National Nursing Home Survey, had a mental health pretest and they found that 22.4 percent of the nursing home population had a diagnosable mental illness.

At this point I would like to address the difference in my 22.4 percent and the information that others have presented with much higher numbers. In Indiana and in many other States, Alzheimer's disease, senility, Organic Brain Syndrome—in other words, the dementias—are not considered to be mental illnesses and are reported separately from mental illness.

We found that the typical mentally ill nursing facility resident needs substantial assistance in at least four of the six activities of daily living. Summarizing the typical mentally ill client in a nursing facility, we found that he or she is elderly, has multiple diagnosis—including both physical and mental diagnosis—needs substantial help with activities of daily living, is appropriately placed in a nursing facility but is not having his or her mental health needs met.

A number of the barriers have already been mentioned by my colleagues, and I'd like to focus on a couple of them—primarily Medicaid and Medicare. Neither program addresses mental health in the same way they do physical health.

For example, in the HCFA conditions of participation for Medicaid certified nursing facilities, it indicates that it is the nursing facilities' responsibility to meet the mental, physical, and psychosocial needs of the residents.

However, in Indiana and in most other States that I'm aware of, mental health services were not figured into the daily per diem rate for services. Every example that is in the Conditions of Participation, such as the utilization of rehabilitation services, uses a physical health example. So people across the country have the perception that mental health is not covered in the same way as physical health services are, and these services were not covered in the daily per diem rates as they were established.

So, therefore, when a person is identified as having a mental illness and needing services, it becomes at best an ancillary service and many times requires a lengthy prior approval process before they can obtain these services.

This, then, raises the question of who's going to provide the service; who's going to pay for these services; and, as was mentioned earlier, the possibility of being—if you identify too many people that have a mental illness diagnosis—being decertified as a nursing facility and reclassified as an IMD.

Problems with Medicare include the low ceiling for services—in 1989 it's scheduled to go $900 annually for outpatient services—and the high coinsurance requirements for outpatient services.

For example, Medicare will pay 62½ percent for outpatient mental health services, whereas, they will pay for 80 percent of outpatient physical health services.

A very major problem that I would like to emphasize is the requirement for on-site physician supervision for outpatient mental health services. As recently as last week, in conversation with a staff member of our State fiscal intermediary for Medicare, he said that as a practical matter, Medicare is not available to provide mental health services for nursing home residents.

Part of our recommendations that we'd like to make for your consideration—and it is in my written testimony—is we would like clarification through the Medicaid program that mental health services are equal in stature with physical health services and should be covered using the same reimbursement mechanism as physical health services. We would like to see changes made in the Medicare programs as I have outlined, and also the elimination of the on-site physician supervision requirement. We feel that case supervision would be perfectly adequate.

Now I'd like to turn to the Omnibus Budget Reconciliation Act of 1987, OBRA '87. We would like to commend Congress for including mental health services in the Nursing Home Reform section of this Act. We are very supportive of the intent of the legislation; that is, to prevent mentally ill persons from being inappropriately placed in nursing facilities and identifying individuals with mental health needs and attempting to see that they get the services they require.

For the first 5 months that this program was in operation in Indiana, we had 10,000 applicants for admission to a nursing facility undergo our Level I assessment. Of these 10,000 people, 71 required a Level II mental illness assessment. Of the 71 people that underwent these assessments, which were conducted by local community mental health centers, 10 persons were actually denied admission. Eight of these persons were denied because they had no physical health reasons why they should be admitted to a nursing facility, and only 2 persons were actually denied because of their mental health condition.

We feel that changes need to be made in the OBRA legislation, particularly in three areas. Two of those areas are that we feel the term "mental illness" and the term "active treatment" both need to be better defined.

For example, we feel that mental illness should be restricted to the five major mental illnesses that are listed in DSM-3, not as currently is in the legislation, everything listed in DSM-3R, which includes things like caffeine addiction, nicotine addiction, et cetera. We think it ought to be narrowly defined to clearly differentiate—and this is the important point I want to make—to clearly differentiate mental health services that can be provided to persons who are appropriately placed in a nursing facility versus inpatient psychiatric care that cannot be provided in such a setting.

This also relates to the definition of "active treatment." Active treatment is a term from the developmental disability field. It is not a mental health term. There is a different understanding of what active treatment means in the mental health field than from the DD field. We would like to see that wording changed to something on the order of psychiatric services, specialized psychiatric

services, or something like that, rather than using active treatment; and to clearly define it as a level of services that need to be provided in an inpatient psychiatric facility in some place other than within a nursing facility.

The final point: The OBRA legislation provides that there's Federal financial participation equal to 75 percent for the preadmission screening and the annual resident review process, but there's nothing included for the "active treatment." Here again is discrimination between physical health services and mental health services. We feel that there should be Federal financial participation in the provision of these services.

Thank you.

Mr. ROYBAL. Thank you, Mr. Mays.

[The prepared statement and supplemental material submitted by Mr. Mays follows:]

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STATEMENT

Respectfully Submitted To The House
Select Committee on Aging

on

Mental Health In Nursing Homes: Barriers and Solutions

Willard L. Hays, M.A.
Director, Older Adult Services
Department of Mental Health
State of Indiana

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August 3, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. THANK YOU FOR THE OPPORTUNITY TO TESTIFY BEFORE YOU TODAY ABOUT THE MENTAL HEALTH NEEDS OF NURSING FACILITY RESIDENTS.

MY NAME IS WILLARD MAYS. I AM THE DIRECTOR OF OLDER ADULT SERVICES FOR THE INDIANA DEPARTMENT OF MENTAL HEALTH. I AM ALSO SPEAKING TODAY ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD) WHICH REPRESENTS THE STATE MENTAL HEALTH AUTHORITIES OF FIFTY FIVE STATES AND TERRITORIES AND IS AFFILIATED WITH THE NATIONAL GOVERNORS' ASSOCIATION. I AM A MEMBER OF THE BOARD OF DIRECTORS OF THE AGING DIVISION OF NASMHPD AND HAVE SERVED AS THE DIVISION'S LEAD PERSON PERTAINING TO THE IMPLEMENTATION OF THE PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) OF MENTALLY ILL NURSING FACILITY APPLICANTS AND RESIDENTS (OBRA '87).

MY TESTIMONY TODAY WILL FOCUS ON THE CURRENT STATUS OF MENTAL HEALTH SERVICES TO NURSING FACILITY RESIDENTS IN INDIANA. I WILL ALSO ATTEMPT TO PUT INTO PERSPECTIVE THE IMPACT THAT FEDERAL RULES AND REGULATIONS AND IN PARTICULAR OBRA 87 IS HAVING ON THE DELIVERY OF MENTAL HEALTH SERVICES TO NURSING FACILITY RESIDENTS.

LET ME BEGIN BY GIVING YOU A FEW FACTS ABOUT THE NURSING FACILITY POPULATION IN INDIANA. THE INDIANA STATE BOARD OF HEALTH REQUIRES THAT EACH NURSING FACILITY SUBMIT AN ANNUAL REPORT THAT INCLUDES STATISTICAL INFORMATION ABOUT THEIR RESIDENTS.

DURING 1987 INDIANA HAD AN AVERAGE DAILY NURSING HOME POPULATION OF 44,937. OF THESE, 38,981 OR 87% WERE SIXTY FIVE (65) YEARS OF AGE OR OLDER. A MENTAL ILLNESS WAS LISTED AS THE PRIMARY DIAGNOSIS FOR 2,305 RESIDENTS OR 5% OF THE TOTAL NURSING FACILITY POPULATION. THIS GROUP IS ALSO PREDOMINANTLY ELDERLY WITH PERSONS SIXTY FIVE (65) OR OVER ACCOUNTING FOR 76% (or 1752) OF THE TOTAL NUMBER. DEMENTIA AND ALZHEIMER'S DISEASE ARE REPORTED SEPARATELY FROM MENTAL ILLNESS.

ANYONE WORKING WITH OLDER ADULTS AND PARTICULARLY NURSING FACILITY RESIDENTS REALIZES, OF COURSE, THAT ONLY LOOKING AT THE PRIMARY DIAGNOSIS IN NO WAY REFLECTS THE MAGNITUDE OF THE PROBLEMS THAT THE INDIVIDUAL HAS. THE NATIONAL INSTITUTE OF MENTAL HEALTH PERFORMED A 1985 PRETEST FOR THE NATIONAL NURSING HOME SURVEY AND FOUND THAT WHEN ALL LISTED DIAGNOSES WERE REPORTED, 22.4% OF NURSING HOME RESIDENTS HAD A DIAGNOSABLE MENTAL ILLNESS.

THE NIMH STUDY ALSO FOUND THAT THE TYPICAL NURSING FACILITY RESIDENT WITH A MENTAL DISORDER NEEDED ASSISTANCE IN AT LEAST FOUR ACTIVITIES OF DAILY LIVING. THE SIX CATEGORIES OF ADL'S INCLUDED IN THE STUDY WERE, IN DESCENDING ORDER OF PREVALENCE, BATHING (82%), DRESSING (68%), TOILETING (50%), CONTINENCE (49%), TRANSFERRING (BED TO CHAIR, ETC.) (45%), AND EATING (38%).

A SURVEY OF OUR 30 LOCAL COMMUNITY MENTAL HEALTH CENTERS (26 RESPONDING) IN 1988 FOUND THAT THE FOLLOWING RELATIONSHIPS WITH NURSING HOMES EXISTED:

- 23 HAD PLANNING OR SERVICE DELIVERY RELATIONSHIPS WITH NURSING HOMES
- 10 HAD A DESIGNATED LIAISON
- 2 HAD A NURSING HOME REPRESENTATIVE ON THEIR BOARD
- 14 PROVIDED CONSULTATION/EDUCATION SERVICES
- 13 PROVIDED INSERVICE TRAINING FOR STAFF
- 18 PROVIDED DIRECT SERVICES (PSYCHOLOGICAL EVALUATIONS, INDIVIDUAL, GROUP AND FAMILY THERAPY)

THESE CENTERS COLLECTIVELY HAD AN ONGOING RELATIONSHIP WITH APPROXIMATELY ONE THIRD OF THE STATE'S NURSING HOMES. THIS SURVEY WAS COMPLETED PRIOR TO THE IMPLEMENTATION OF OBRA.

SEVERAL CONCLUSIONS THAT CAN BE DRAWN FROM OUR EXPERIENCE IN INDIANA AND FROM RESEARCH NATIONALLY ARE THAT THE AVERAGE NURSING HOME RESIDENT WITH A MENTAL DISORDER:

1. IS ELDERLY,
2. HAS MULTIPLE DIAGNOSES INCLUDING NUMEROUS PHYSICAL HEALTH PROBLEMS,
3. NEEDS SUBSTANTIAL ASSISTANCE WITH ACTIVITIES OF DAILY LIVING,
4. IS APPROPRIATELY PLACED IN THE NURSING FACILITY AND DOES NOT NEED TO BE MOVED TO A MENTAL HEALTH FACILITY, BUT
5. IS NOT HAVING HIS/HER MENTAL HEALTH NEEDS ADEQUATELY ADDRESSED.

I WOULD NEXT LIKE TO ADDRESS SEVERAL BARRIERS THAT I FEEL ARE INHIBITING THE ADEQUATE PROVISION OF MENTAL HEALTH SERVICES TO NURSING HOME RESIDENTS.

FIRST OF ALL, THE CURRENT CONDITIONS FOR PARTICIPATION FOR MEDICAID CERTIFIED NURSING FACILITIES, AND THE PROPOSED NEW ONES, WHICH I UNDERSTAND HAVE BEEN DELAYED, BOTH STATE THAT IT IS THE NURSING FACILITY'S RESPONSIBILITY TO MEET THE MENTAL, PHYSICAL AND PSYCHOSOCIAL NEEDS OF THEIR RESIDENTS. UNFORTUNATELY, AS THE CONDITIONS OF PARTICIPATION HAVE BEEN IMPLEMENTED, THE EMPHASIS HAS CLEARLY BEEN ON MEETING THE RESIDENTS' PHYSICAL HEALTH NEEDS. IN INDIANA, AND I AM SURE MANY OTHER STATES, MENTAL HEALTH SERVICES WERE NOT FIGURED INTO NURSING FACILITY PER DIEM RATES. AT BEST, MENTAL HEALTH SERVICES BECOME AN ANCILLARY SERVICE FREQUENTLY REQUIRING A LENGTHY PRIOR APPROVAL PROCESS.

THERE ARE ACTUALLY DISINCENTIVES FOR A NURSING FACILITY TO IDENTIFY MENTAL HEALTH NEEDS AND TO ARRANGE FOR MENTAL HEALTH SERVICES. WHO IS GOING TO PROVIDE THE SERVICE AND WHO IS GOING TO PAY FOR IT?

ANOTHER RISK THAT A NURSING FACILITY FACES IS THAT BY IDENTIFYING TOO MANY RESIDENTS WITH MENTAL HEALTH PROBLEMS, IT RUNS THE RISK OF BEING DECERTIFIED AS A NURSING FACILITY AND BEING RECLASSIFIED AS AN INSTITUTION FOR MENTAL DISEASES (IMD).

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PROBLEMS WITH MEDICARE INCLUDE A LOW CEILING OF COVERAGE AND A HIGH CO-INSURANCE REQUIREMENT FOR OUTPATIENT TREATMENT WHICH DISCOURAGE CLIENTS FROM SEEKING SERVICES. MEDICARE ONLY COVERS 62.5% FOR OUTPATIENT MENTAL HEALTH CARE COMPARED TO 80% COVERAGE FOR PHYSICAL HEALTH OUTPATIENT SERVICES.

A SIGNIFICANT PROBLEM IS THE MENTAL HEALTH OUT-PATIENT REQUIREMENT FOR ON-SITE PHYSICIAN SUPERVISION WHICH EFFECTIVELY PREVENTS PAYMENT FOR SERVICES PROVIDED OUTSIDE THE MENTAL HEALTH FACILITY, SUCH AS IN A NURSING FACILITY, BY ANYONE OTHER THAN A PSYCHIATRIST. AS RECENTLY AS LAST WEEK A STAFF MEMBER OF OUR STATE MEDICARE FISCAL INTERMEDIARY ADVISED ME, THAT AS A PRACTICAL MATTER, MEDICARE COVERAGE FOR MENTAL HEALTH SERVICES IS NOT AVAILABLE FOR RESIDENTS WITHIN A NURSING FACILITY.

ON BEHALF OF NASMHPD I WOULD LIKE TO COMMEND CONGRESS ON THE INCLUSION OF MENTAL HEALTH IN THE NURSING HOME REFORM SECTION OF OBRA 87. WE FIRMLY SUPPORT THE TWO MAJOR PURPOSES OF THE LEGISLATION, THAT IS PREVENTING INAPPROPRIATE PLACEMENT OF MENTALLY ILL PERSONS IN NURSING FACILITIES AND PROMOTING THE PROVISION OF MENTAL HEALTH SERVICES FOR PERSONS WHO ARE APPROPRIATELY PLACED THERE.

THE PREADMISSION SCREENING PROCESS FOR MENTALLY ILL AND MENTALLY RETARDED (AND RELATED CONDITIONS) NURSING FACILITY APPLICANTS WAS REQUIRED TO BE IN OPERATION BY JANUARY 1 OF THIS YEAR. INDIANA HAD THE ADVANTAGE OF HAVING A PREADMISSION SCREENING PROGRAM IN EXISTENCE SINCE 1983. WE BUILT THE LEVEL I OR PRELIMINARY SCREEN INTO OUR EXISTING PROGRAM. THE FIRST FIVE MONTHS OF THE PROGRAM WE HAD A LITTLE OVER 10,000 PERSONS APPLY FOR ADMISSION AND UNDERGO THE LEVEL I SCREEN.

SEVENTY ONE OF THESE APPLICANTS REQUIRED A LEVEL II (MORE COMPREHENSIVE) MENTAL ILLNESS ASSESSMENT WHICH ARE BEING PERFORMED BY OUR LOCAL COMMUNITY MENTAL HEALTH CENTERS. AS A RESULT OF THIS ASSESSMENT TEN PERSONS WERE DENIED ADMISSION AND EIGHT OF THESE WERE BECAUSE THEY DID NOT HAVE THE MEDICAL NEEDS TO WARRANT NURSING FACILITY LEVEL OF CARE. ONLY TWO PERSONS WERE DENIED BECAUSE OF THEIR MENTAL HEALTH CONDITION.

OUR ANNUAL RESIDENT REVIEW PROCESS BEGAN IN MARCH. SPECIFIC NUMBERS ARE NOT YET AVAILABLE BUT PRELIMINARY INDICATIONS ARE THAT VERY FEW PEOPLE WILL HAVE TO BE MOVED BECAUSE OF THEIR MENTAL HEALTH CONDITION. WE CONTINUE TO BELIEVE THAT MANY RESIDENTS WILL BE IDENTIFIED WITH MENTAL HEALTH NEEDS BUT NOT AT THE LEVEL WHERE THEY NEED TO BE MOVED TO A PSYCHIATRIC HOSPITAL, MENTAL HEALTH CENTER INPATIENT UNIT OR A MENTAL HEALTH RESIDENTIAL PROGRAM.

ALTHOUGH WE SUPPORT THE CONCEPT OF THE MENTAL HEALTH CONTENT IN THE NURSING HOME REFORM SECTION, THE LEGISLATION AND THE IMPLEMENTATION GUIDELINES ISSUED BY HCFA HAVE CREATED SIGNIFICANT PROBLEMS FOR STATES, THE HEALTH AND MENTAL HEALTH SYSTEMS AND MOST IMPORTANTLY FOR THE APPLICANTS/RESIDENTS AND THEIR FAMILIES.

A FEW SPECIFIC EXAMPLES INCLUDE:

1. THE OBRA LEGISLATION REQUIRES STATES TO PROVIDE "ACTIVE TREATMENT" BUT PROVIDES NO FEDERAL FUNDING TO DO SO. WHAT IS "ACTIVE TREATMENT", WHO IS TO PROVIDE IT, AND HOW IS IT TO BE PAID FOR?
2. THE FEDERAL CRITERIA (FOURTH DRAFT, MAY 89) ISSUED BY HCFA CLEARLY STATE THAT RESIDENTS, WHO AFTER BEING ASSESSED ARE FOUND NOT TO HAVE A CERTAIN LEVEL OF MEDICAL NEEDS AND ALSO NOT TO NEED ACTIVE PSYCHIATRIC TREATMENT, MUST BE DISCHARGED. FOR THESE INDIVIDUALS IT DOESN'T MAKE ANY DIFFERENCE IF THEY ARE OF ADVANCED AGE OR HOW LONG THEY HAVE LIVED IN THE NURSING FACILITY. WHERE ARE THESE PEOPLE TO BE PLACED AND WHO WILL PAY FOR THEIR CARE?
3. WE HAVE ALREADY ENCOUNTERED SEVERAL CASES WHERE PSYCHIATRIC INPATIENT UNITS ARE REFUSING TO ACCEPT CURRENT OR POTENTIAL NURSING HOME RESIDENTS. THE BOTTOM LINE IS THAT THEY FEEL THEY MAY NOT BE ABLE TO DISCHARGE THE PERSON TO A NURSING FACILITY FOLLOWING TREATMENT.

AN ACTUAL CASE INVOLVED AN ELDERLY MAN WHO WAS SEEKING ADMISSION TO A NURSING HOME BECAUSE OF HIS WORSENING PHYSICAL CONDITION AND THE FACT THAT THE ROOM AND BOARD ASSISTANCE (RBA) PROGRAM IN WHICH HE CURRENTLY LIVED WAS CLOSING. THE PREADMISSION ASSESSMENT FOUND THAT HE DID NOT HAVE SUFFICIENT MEDICAL NEEDS FOR ADMISSION TO A NURSING HOME AND NEEDED INPATIENT PSYCHIATRIC CARE. NO MENTAL HEALTH FACILITY WOULD ADMIT HIM BECAUSE OF HIS PHYSICAL CONDITION. HE COULD NOT BE MOVED TO ANOTHER RBA BECAUSE THERE IS A PROHIBITION IN STATE LAW AGAINST PLACING A MENTALLY ILL PERSON IN THE PROGRAM. THE SITUATION WAS EVENTUALLY RESOLVED WHEN HE FELL AND BROKE HIS HIP AND WAS ADMITTED TO A NURSING HOME FROM AN ACUTE CARE HOSPITAL.

I HAVE ATTEMPTED TO SUMMARIZE BRIEFLY FOR THE COMMITTEE THE EXTENT OF THE PROBLEM AND THE BARRIERS THAT EXIST PREVENTING ADEQUATE PROVISION OF MENTAL HEALTH SERVICES TO NURSING HOME RESIDENTS. I WOULD NOW LIKE TO SUBMIT THE FOLLOWING RECOMMENDATIONS FOR POLICY AND LEGISLATIVE CHANGES THAT I BELIEVE WILL HELP ALLEVIATE THE PROBLEMS THAT I HAVE DESCRIBED.

1. THE MEDICARE PROGRAM SHOULD BE MODIFIED TO PROVIDE COVERAGE FOR MENTAL HEALTH SERVICES ON AN EQUAL BASIS WITH PHYSICAL HEALTH SERVICES. THE REQUIREMENT FOR "ON-SITE" SUPERVISION BY A PHYSICIAN FOR OUTPATIENT MENTAL HEALTH SERVICES SHOULD BE ELIMINATED.

2. THE MEDICAID PROGRAM SHOULD BE REVISED TO MAKE IT CLEAR THAT MENTAL HEALTH SERVICES ARE AS IMPORTANT AND EQUALLY AVAILABLE AS MEDICAL SERVICES AND ARE REIMBURSABLE USING THE SAME FUNDING MECHANISMS.

3. THERE SHOULD BE A CLEAR DIFFERENTIATION BETWEEN MENTAL HEALTH SERVICES FOR PERSONS APPROPRIATELY IN A NURSING HOME AND "ACTIVE PSYCHIATRIC TREATMENT" WHICH IS OVER AND ABOVE WHAT A NURSING HOME CAN PROVIDE. I SUGGEST TWO AMENDMENTS TO OBRA TO ACCOMPLISH THIS:

   A. CHANGE "ACTIVE TREATMENT" TO "SPECIALIZED PSYCHIATRIC SERVICES" AND DEFINE IT AS SERVICES PROVIDED OUTSIDE OF THE NURSING HOME IN AN INPATIENT PSYCHIATRIC FACILITY.

   B. DEFINE "MENTAL ILLNESS" FOR THE PURPOSES OF OBRA AS BEING LIMITED TO SCHIZOPHRENIC, PARANOID, MAJOR AFFECTIVE AND SCHIZOAFFECTIVE DISORDERS AND ATYPICAL PSYCHOSIS.

4. THE FEDERAL GOVERNMENT NEEDS TO PARTICIPATE IN THE FUNDING OF "ACTIVE TREATMENT" OR "SPECIALIZED PSYCHIATRIC SERVICES".

I WOULD ALSO LIKE TO SUBMIT TWO REPORTS ISSUED BY THE TASK FORCE ON THE MENTAL HEALTH NEEDS OF OLDER HOOSIERS, INC., THESE TWO DOCUMENTS COVER IN GREATER DETAIL A NUMBER OF THE ISSUES THAT I HAVE ADDRESSED. THE TASK FORCE WAS SPONSORED BY THE INDIANA FEDERATION OF OLDER HOOSIERS WHICH REPRESENTS OVER 30 STATEWIDE AGING ORGANIZATIONS IN INDIANA.

THANK YOU FOR THE OPPORTUNITY TO ADDRESS THE COMMITTEE AND I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS THAT YOU MIGHT HAVE.

QUESTIONS FOR WILLARD MAYS, REPRESENTING THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS.

1. Your testimony refers to several policy and legislative changes that should be implemented to facilitate access to mental health services for the nursing home resident. Are there any other changes necessary and in your opinion which changes would take the highest priority?

2. You noted in your testimony that 23 of Indiana's local community mental health centers had planning or service delivery relationships with nursing homes. Could you describe some of these programs for us?

3. What would you consider active treatment of the elderly mentally ill population?

State of Indiana

Evan Bayh, Governor

DEPARTMENT OF MENTAL HEALTH

117 East Washington Street
INDIANAPOLIS, INDIANA 46204 - 3647

COMMISSIONER
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Information
and Public Affairs
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Reimbursement
232-7889

August 17, 1989

U.S. House of Representatives
Select Committee on Aging
300 New Jersey S.E.
Annex 1, Room 712
Washington, D.C. 20515

I want to again thank the Select Committee on Aging for the opportunity to testify at the recent hearing on the mental health needs of nursing home residents. I hope that my testimony was beneficial and appreciate the opportunity to provide additional information by answering the three questions that you sent me.

Question #1

I believe that the three most important policy and legislative changes needed are:

1. Modifications to the Medicaid law and regulations providing for coverage of mental health services equal to that for physical health services. It should be made clear that it is the responsibility of the nursing facility to provide or arrange for the provision of mental health services for persons appropriately placed there and that Medicaid will pay for the services for Medicaid eligible residents.

2. Modification of the Medicare law and regulations providing for equal coverage of mental health services. The requirement of on site physician supervision for out-patient mental health services needs to be modified to allow for case supervision.

3. Amend OBRA '87 legislation related to the definition of mental illness and active treatment per my testimony and recommendations from the National Association of State Mental Health Program Directors. The Federal Government needs to participate in the funding for the mental health services that the state is required to provide.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION AGENCY

I also support the concept of the Wyden (HR1453) - Rockefeller (S785) bills related to a new Medicaid State Option for the Frail Elderly. The bills should include coverage for persons with mental health problems and also for persons with both mental and physical problems.

Question #2

All of our 30 Community Mental Health Centers are currently participating in the OBRA program. Additionally they are providing services to nursing homes such as consultation and education, staff training, individual and group therapy, support groups etc.

The Swanson Center operates a full time multipurpose senior center in LaPorte, Indiana. One of their programs is their "Sunshine Group" which meets every Friday. This is a day activity program at the center for nursing home residents. Currently an average of 15 residents from four facilities participate each week. Activities range from handicrafts to group therapy.

I have also enclosed a copy of "Nursing Homes and Community Mental Health Centers" which includes other examples of programs that can be provided. It was developed by a task force of the Indiana Council of Community Mental Health Centers.

Question #3

The term "Active Treatment" should be changed to "Specialized Mental Health Services" and be defined as an acute episode of a severe mental illness requiring inpatient care in a psychiatric facility. This level of service should not be provided in a nursing facility. This needs to be clearly different from mental health services that can be provided by the nursing home or on an outpatient basis by mental health professionals.

If I can answer any other questions or provide any additional information please don't hesitate to contact me. My telephone number is (317) 232-7894.

Sincerely,

Willard L Mays

Willard L. Mays, Director
Older Adult Services

WLM/tma

Mr. ROYBAL. The Chair recognizes Mr. Hogan.

STATEMENT OF JOHN H. HOGAN, ADMINISTRATOR, BENEDICTINE NURSING CENTER, MOUNT ANGEL, OREGON

Mr. HOGAN. Thank you, Mr. Chairman. I also would like to express my gratitude for seeing a group like this come together. I think it's time that providers and practitioners begin dealing with these issues face-to-face. As an administrator of a long-term care facility, we also are impacted by a number of the things we have talked about today, and I'll cover those briefly.

Our formal testimony has been submitted on behalf of the American Association of Homes for the Aging, and I'll just highlight some of my specific concerns.

I would like to just take a moment to comment on a couple of items that have come up that concern me. One is just in terms of the stereotyping that long-term care has experienced—certainly throughout my career and I think since Day One—and that's the use of terminology such as "warehousing," "placement of people inappropriately," and so forth. I think those kinds of terms do not help us get at the issues that we're trying to deal with. In fact, I think they tend to spread the guilt that families often deal with in terms of placement of a family member in a long-term care setting.

The second issue has to do with staffing, and I'd like to just express our support for the millions of nurses and nurse aides who do outstanding work. The people who create the problems get all the press, but I think the other side of the situation is that we have millions of people who do outstanding work—and it's difficult work. When we talk about the training needs, we must remember that if those training programs are not there, it is not the individual's fault; it's the system's fault.

In terms of the American Association of Homes for the Aging, as evidenced by our membership, we are committed to providing for the physical, social, emotional, psychological, and spiritual needs of our residents.

The need for mental health services is well established. We all know what the numbers are, and we've heard them again today, and we all know what the problems are in the settings. Basically, I think you've already had identified for you today the three populations of elderly in nursing homes who must be considered when we assess the mental health needs in long-term care.

You've heard about the deinstitutionalized elderly. While the current population is not a significant population as you've heard, certainly we have concerns as institutions are downsized. The potential impact of that population again impacting long-term care as institutions are closed is a very real issue.

Another population includes those individuals with late onset of mental health problems; and a third one is the ill elderly with associated mental health problems.

Facilities are doing a number of things creatively, I think, to deal with these particular populations. And I think various approaches are really needed in terms of mental health services. An example in our setting is a program we call "Serve" which is a program that deals with the confused elderly, and is an exercise pro-

gram. The results of that program which I think can be demonstrated in any setting, as well as any place in the United States, is that these people really improve not only in terms of behavior, but also in terms of their ability to associate with other patients.

In terms of OBRA, I have just a couple of comments.

Our formal written testimony again details our positions on OBRA and some of the provisions which concern us. I'd just like to express that the implementation of OBRA has been an unequivocal disaster for patients and families alike as well as facilities.

I think this past spring, with the implementation of preadmission screening with no guidelines in place, and established procedure to follow, the people hurt by this process the most were the patients themselves.

I'd ask this committee and Congress to really take a close look at the implementation process as OBRA continues to be implemented.

I could sit here and recount stories related to the implementation of the preadmission screening process where admissions were delayed, and where discharges were delayed. And I'd only ask, as those other elements of OBRA come into place, that the implementation process really be published and distributed so that people are ready to deal with the issues before the fact, rather than after the fact.

The barriers that we see to providing mental health services in nursing homes certainly have been identified here. Reimbursement is by far the most critical area. In this hearing we're talking about expanding which are currently nonexistent. We need to address establishing new programs in terms of reimbursement.

That few mental health professionals are available has been voiced by a number of people on the panel, and that's critical throughout the field. Certainly we're fortunate to have some of these people at our facility, but I think the need is extensive throughout the country.

A third area that we want to mention is survey teams. We feel that survey teams are untrained with geriatric populations as a whole, and they almost never include mental health professionals. To creative programs, this presents an incredible problem. You have a survey team coming in trying to evaluate what you're doing for patients in terms of creative mental health programs and approaches. Basically, survey teams have no understanding of what you're trying to do, so they attack your attempts at being creative.

I think there's a real need to upgrade not only the level of our survey teams but also to bring a mental health component into those teams.

In closing, I don't think it's all lost. I think, if anything, we do see a lot of solutions. Those are mentioned in our testimony. But I think it's really clear that we have to take a look at the populations we're trying to serve. I don't think our settings are the appropriate settings for the acutely or chronically mentally ill.

I think the populations we identified are the ones that we feel we need to continue to serve.

The solutions certainly are in terms of reimbursement issues. Somebody mentioned positive reimbursement and I think that's really critical. There's reimbursement, and there's reimbursement. The incentive to get people to provide the services is what we're

talking about, not just laying a few dollars out there and saying "do it."

In terms of the education issue, I think we have to expand the educational and grant opportunities in this particular field. As a teaching-nursing home, affiliated with Oregon Health Sciences University, we get undergraduate, graduate, and post-doctoral mental health students rotating through our facility and working with our patients and with our programs.

I think these are the kinds of programs that we need throughout the country if we're going to create an interest in this field on the part of practitioners.

I wish to thank you, Mr. Chairman, for the opportunity to speak today.

[The prepared statement and supplemental material submitted by Mr. Hogan follows:]

A A H A

Statement by

John H. Hogan
Administrator
Benedictine Nursing Center
Mount Angel, Oregon

on behalf of

The American Association of Homes for the Aging

before the

House Select Committee on Aging

United States House of Representatives

on

"Mental Health in Nursing Homes: Barriers and Solutions"

August 3, 1989

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TESTIMONY OF JOHN H. HOGAN
REPRESENTING THE
AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman and Members of the Committee, I am John Hogan, Administrator of the Benedictine Nursing Center in Mount Angel, Oregon. The Benedictine Nursing Center is a 130 bed skilled and intermediate care facility located in a rural area of our State.

I am pleased to be here today representing the American Association of Homes for the Aging (AAHA). AAHA is a national, nonprofit association representing over 3,500 not-for-profit facilities providing health care, housing, continuing care retirement programs, and community services to more than 500,000 older individuals every day. Seventy-five percent of AAHA homes are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups.

On behalf of AAHA, I would like to thank the Committee for this opportunity to present our views on the availability of, and need for, mental health services in nursing homes. With a tradition of strong community involvement and long-standing community ties, our members remain committed to meeting the physical, social, emotional, psychological, and spiritual needs of long-term care residents in a manner which enhances their sense of self-worth and dignity and allows them to function at their highest level

of independence. Certainly, doing our best to meet the mental health needs of residents is part of that commitment.

Mr. Chairman, today I would like to briefly discuss a number of topics with the Committee, including: the need for mental health services in nursing homes; the types of residents with mental health care needs; the kinds of expectations one has for nursing facilities in this regard; barriers to service; and possible solutions.

THE NEED FOR MENTAL HEALTH SERVICES IN NURSING HOMES

The need for mental health services among the elderly in nursing homes is well-documented and indisputable. It has been estimated that 56 to 80 percent of the 1.5 million residents of long-term care facilities in the United States have diagnosable dementias or some degree of cognitive impairment, mental conditions, and/or forms of behavior problems. The most common of these diagnoses and behaviors include Alzheimer's Disease and related dementias, depression, wandering, confusion, disorientation, withdrawal lethargy, agitation, stress reaction, dependency, apathy, and irritability.

The projected demographics of this country's aging process for the next 20 years are sufficient in and of themselves to anticipate that the presence of conditions such as those cited above will increase among elderly nursing home residents, and that there will be a concomitant need for greater

availability of mental health services for this population. The United States Census Bureau estimates that the over-85 population, those individuals at highest risk for nursing home care, will more than double during this period. This points not only to a growth in the number of elderly who will require nursing home care, but also to a probable rise in the average age of the nursing home resident. Since the incidence of dementias and certain disorders, such as depression, appear to increase with age (Harper, Mental Illness in Nursing Homes: Agenda for Research, 1986), new admissions to nursing homes, as well as long-stay residents, are likely to include greater numbers of the elderly who are in need of mental health services.

WHO ARE THE MENTALLY ILL IN NURSING HOMES?

There are at least three distinct populations of elderly nursing home residents who must be considered in assessing the need for mental health services in the long-term care setting.

"Deinstitutionalized" Elderly. The first group consists of those individuals whose placements years ago in nursing facilities were the consequence of nation-wide efforts to depopulate public mental hospitals. Until the 1950's, placement for the majority of Americans with diagnosed chronic mental illness, including those of advanced age, was generally sought in State-operated mental facilities. Deinstitutionalization efforts over the past thirty years have resulted in a 70% reduction nationwide of

the populations of these facilities. However, since the development of expected community programs for the mentally ill has not kept pace with deinstitutionalization, alternative institutional remedies, e.g. hospital emergency and inpatient services, as well as short-term readmissions to the same mental health facilities, have remained the dominant source of care for many of these individuals.

Some contend that, particularly for many of the elderly mentally ill, the 1965 - 1967 enactments of the Medicare and Medicaid amendments to the Social Security Act dramatically impacted the outcome of deinstitutionalization. While deinstitutionalization was, and to some extent still is, considered revolutionary in terms of our approach to caring for the aged mentally ill, many believe that, at least for some States, the advent of Federally-subsidized long-term care offered an opportunity to offset fiscal responsibilty for caring for older mental patients and that this precipitated the inappropriate placement by some States of individuals into nursing homes. We acknowledge that some inappropriate placements did occur. We also recognize, however, that among these populations of deinstitutionalized persons, there were persons for whom the care needs related to mental illness had diminished to a point of lesser concern than those care needs related to normal aspects of the aging process, including the onset of organic brain syndrome. In other words, the existence or history of mental illness notwithstanding, these individuals were simply growing old. Placement in a nursing home may have been considered appropriate for these persons given their deteriorated

physical status and the accompanying need for continued care.

Aside from the unique problems presented by deinstitutionalization, the debate continues about the appropriate placement of mentally ill who become old without becoming well. Clearly there is a point at which the scale is tipped toward the nursing care needs commonly experienced by the whole spectrum of the aging population and away from the focus of the mental illness which formed the basis of intervention for these people in their younger years. I would like to stress that this debate is now more than academic. While the large-scale emigrations of people from mental hospitals to the community have generally been accomplished, the presence of the frail elderly with a history of mental illness can only increase as people continue to live longer and continue to experience mental disorders during the course of their lives. It is estimated that eight (8%) to ten (10%) percent of current nursing home residents are former residents of State or other long-term care psychiatric specialty hospitals (Lebowitz, Mental Health Policy & Aging, 1988). Given the increasing longevity of these individuals, this is a population we expect to serve for a good many years.

Late Onset Mental Health Problems. The second population of mentally ill in nursing homes to consider includes those persons who have led full and independent lives until their advanced years, and who are admitted to nursing homes with mental health care needs symptomatic of an organic or medical condition, i.e., the onset of dementia or a disorder associated

with cerebral arteriosclerosis or a cerebral vascular disturbance. This group represents individuals — and families — who are experiencing mental health problems for the first time. For most, these problems are of a permanent and increasingly debilitative nature.

Ill Elderly With Associated Mental Health Problems. The third and final group is composed of those elderly nursing home residents with physical illnesses who develop associated psychiatric, emotional, or behavioral conditions. Much of this type of psychopathology is the result of the resident's acute awareness of his/her physical deterioration and decreasing functional abilities - the resident knows that old age is rapidly encroaching and fears it. These disorders are also likely to be compounded by other crises common to aging such as diminishing control over one's environment, and the deaths of spouse or relatives, and friends. Depression is the most common of these disorders, occurring in an estimated 10 - 13% of the nursing home population. For this group, there is the possibility that programs by nursing facilities to improve the quality of life, together with appropriate medical care, can contribute to an improvement on the part of the resident.

EXPECTATIONS FOR MENTAL HEALTH CARE IN NURSING FACILITIES AND CURRENT PATTERNS OF CARE

Any assessment of the existing mental health services for long-term care residents, as well as any proposals to enhance or improve these services,

must be prefaced with a discussion of the underlying structure and function of the nursing facility.

We note that the statutory definitions of nursing homes, Sections 1861(j) and 1905(c)) of the Social Security Act, are clearly separate and distinct from the definitions of both Institutions for Mental Diseases (IMDs) and Intermediate Care Facilities for the Mentally Retarded (ICFs MR). The primary focus in the design of standards for both skilled and intermediate care nursing facilities was directed toward meeting the nursing and/or medical needs of the residents. For more than 20 years, it has been these definitions and standards, based in the traditional medical model for care, which have shaped the populations, the treatment modes, and the overall character of the nursing home setting.

As detailed above, virtually all of the physically disabling, or potentially disabling, conditions experienced by elderly individuals in nursing homes also have behavioral, emotional, and mental health components which must be addressed. For that reason, it has become a generally accepted tenet of geriatric treatment planning that quality of care and quality of life issues, particularly in nursing homes, cannot be adequately responded to through use of a pure medical model. However, since it is also true that it is the need for medical services which remains the driving eligibility factor for admission to a long-term care facility, the extent to which mental health services can and should be provided within the context of the nursing home setting remains controversial.

In detailing the different nursing home populations with mental health care needs above, one segment of mentally ill persons was clearly omitted - those individuals for whom the diagnosis of mental illness remains the primary and dominant, if not exclusive, focus of their need for care.

There is a reason that reference to these individuals was excluded from our description of the mentally ill in nursing homes; mainly that we do not believe that nursing homes are the appropriate setting in which to meet the needs of the acutely and chronically mentally ill.

As you are probably aware, AAHA was a very active member of the Campaign for Quality consensus process which followed the February, 1986 publication of the Institute of Medicine report on the Quality of Care in Nursing Homes. As part of this process AAHA revisited the position of its members on the provision of mental health services to their long-term care residents. While all agreed that mental health care must certainly be considered as one aspect of meeting the total needs of residents, our members also overwhelmingly expressed their desire to retain the overall character of their facilities as nursing homes and their primary function as providers of services to the aged. AAHA members believe that, as long-term care settings primarily designed to serve the frail elderly, we are both poorly equipped and generally unable to meet the needs of persons who are acutely and chronically mentally ill. Nursing homes, as the Social Security Act currently defines them, lack the capability in terms of specialized staffing, physical structure, and the overall character of

their populations to manage many of the behaviors and manifestations common to major mental illnesses and to provide an adequate response to individuals who require long-term and intensive psychotherapy. Expectations regarding the degree of mental health intervention which can be offered must be balanced against both facility's ability to provide the service and the possible outcomes for bo the resident and the remaining population.

What Facilities are Doing Now

The inability to care for the acutely mentally ill, notwithstanding, many facilities have instituted innovative programs and approaches to respond to the mental health needs of the residents they can serve. As I mentioned above, many of the problems and behaviors exhibited by nursing home residents can be traced to a sense of loss of individuality or independence, loss of control over their environment, or fear of being alone or abandoned by family or friends. Facilities have found that these problems can often be successfully managed by beginning with an evaluation of the individual's personal strengths and the subsequent direction of these assets to activities where the resident feels useful and helpful to others. Additionally, while the number of nursing facilities that include full-time mental health professionals as a regular staff component is admittedly limited, many homes refer to and consult with psychiatrists, psychologists, psychiatric social workers, and other clinical specialists on an as-needed basis in response to resident needs and behaviors. In

these instances the mental health professional will work with the resident and staff, both individually and together, to develop an approach to resolving a particular problem and to develop a treatment plan which can be implemented, and modified if necessary, on an ongoing basis by staff within the facility. These homes frequently consult with mental health professionals to develop behavioral responses to ameliorate problems in such areas as social skills, social isolation, and inactivity or lethargy. Programs involving familiar activities, the creation of environments which allow freedom to wander without endangering the resident, and approaches such as reality and reminiscence therapy have also helped residents with dementias continue to participate in and relate to many daily life functions.

Speaking for my own situation, the Benedictine Nursing Center formed a mental health deparment, staffed by psychiatric clinical nurse specialist, approximately eleven years ago. This department was designated with the responsibility of developing, implementing and maintaining standards of care, and policies and procedures related to the mental health needs of the residents. We also maintain a relationship with the School of Nursing of the Oregon Health Sciences University. Through this arrangement, which allows students from the school to rotate through our factility, these young professionals are ensured an up-to-date and in-depth knowledge of the mental health problems of the elderly. Of course, a side benefit for Benedictine is also the vitality these students bring to the residents. Over the past eleven years a variety of innovative programs have been

developed with an emphasis on cost effective delivery of quality mental health services to the nursing home residents and their famililes, and mental health education and skills for the staff. For example, specific communication techniques were developed to be used with confused residents. These are taught regularly to all staff members through our aide training classes, frequent inservices, role modeling and video tapes.

At Benedictine, we also avoid reliance on behavior-modifying drugs if at all possible, although we acknowledge that drug intervention may be appropriate in some special cases. I realize that nursing facilites have been accused of relying on drug therapies rather than other treatment modes in response to mental health needs, and we fully support the current emphasis on reevaluating and avoiding the over-use of psychotropic drugs in nursing homes. But, while Benedictine has found it possible to drastically reduce the use of these chemical restraints through the use of approaches such as those described above, we believe it is also true that limited use of these medications in conjunction with other treatment modes and supports may prove beneficial to many nursing home residents and help to avoid the unnecessary transfer of these individuals to unfamiliar and possibly counter-productive settings.

CHMA '87

In implementing some of the programs I have described, we find ourselves both helped and hindered by the nursing home quality reform provisions of

the Omnibus Budget Reconciliation Act of 1987. One of the most controversial provisions of this law has been the requirement that all applicants and residents of nursing facilities be subject to preadmission screening and an annual review for the presence of mental illness or mental retardation. Following the pre-admission screening or annual review a subsequent determination must be made of need for nursing services and/or active treatment. Current statutory language also mandates that residents with mental retardation or mental illness in need of active treatment who have resided in facilities for more than 30 months be offered the option to remain at the home. Residents who have have resided in the facility for less than 30 months and who require active treatment must be discharged. A critical element of this provision is the requirement that the State must provide, to those residents who elect to remain in the nursing facility, all appropriate active treatment services. While the Health Care Financing Administration's implementation of the law has provided little guidance to States in this regard, the provision of active treatment has been generally assumed to be a term of art in the context of both mental illness and mental retardation. States, providers, and consumers have anticipated that definitions of active treatment for both mental illness and mental retardation would be forthcoming to clarify in detail what the provision of these services would entail. Thus far, all we have received is non-binding guidance to State Medicaid Programs.

The purpose of this provision was to prevent the inappropriate placement of mentally ill and mentally retarded residents nursing facilities. As

implemented, however, this is acting to delay or deny access to needed services for the individuals it was intended to benefit.

Recent amendments to the House Energy and Commerce Reconciliation package for FY 1990 included several proposals which we believe will clarify problems we have had with the screening requirement. We are, however, concerned about one proposal which would delete the term active treatment in favor of language that would require the provision of specialized services to all nursing home residents with mental illness or mental retardation. Based on our discussion above regarding the overall character and function of nursing facilities, we are extremely concerned with the generic nature of this proposed change in nomenclature. This change in terminology raises the question of what services we will routinely be expected to require and who we will routinely be expected to serve. Our concern is that the use of "specialized services" will be interpreted by the Administration to require that nursing homes now become "all things to all people" in the context of mental health services, including the provision of care to the acutely mentally ill; and that the burden of providing services would be shifted from the States to the nursing homes.

BARRIERS TO THE PROVISION OF MENTAL HEALTH SERVICES IN NURSING HOMES

Although I have been able to share with you a few of the mental health programs that have been established by Benedictine and others, it remains

true that in most facilities the mental health needs of the residents go unmet to a great extent. There are several reasons for this disparity between needs and services:

- Traditional Federal policy has delegated care of the mentally ill to the States. Reimbursement for the care of mental disorders under both the Medicare and Medicaid programs is either non-existent or substantially less than for physical illness. Medicare payment for nursing home services covers only skilled nursing care and does not include coverage for psychiatric or psychological services. To qualify for reimbursement, inpatient mental health services must be delivered in psychiatric facilities where the lifetime benefit permits only 190 days of treatment (Jazwiecki & Press, Mental Illness in Nursing Homes, 1986). This lack of coverage serves to limit many elderly residents of nursing homes to the services of a physician who may be untrained and ill-equipped to meet geriatric mental health needs.

  The provision of mental health services under the Medicaid program has been directly affected by the policy of the Health Care Financing Administration to disallow federal financial participation (FFP) to facilities for services rendered in nursing homes which HCFA finds to qualify as institutions for mental diseases (IMDs). HCFA's Guidelines for Making IMD Determinations (Transmittal No. 20, September, 1986) sets out ten (10) specific criteria for establishing whether the

"overall character" of a facility is that it "is established or maintained primarily for the care and treatment of individuals with mental diseases." One of these criteria in particular is critical to the provision of mental health services in Medicaid-certified nursing homes. This is the "50%" percent rule which categorizes the facility as an IMD if more than half of its residents are determined to have mental diseases which require inpatient treatment. This "Rule" has served to inhibit the development and provision of services to residents since facilities can never be sure what type of programs will be considered the within boundaries of inpatient care for mental illness. Similarly, while the HCFA Guidelines specifically exempt persons with senility or organic brain syndrome from this classification system, the Administration includes the qualifier that these diagnoses shall not be considered mental diseases "if the facility is appropriately treating the patients by providing only general nursing care." Finally, the retention of mental health professionals as routine components of nursing home staff or the intervention of mental health training into facilities' regular training programs has been inhibited by the criteria which categorizes an IMD by the fact that "an unusually large portion of staff has specialized psychiatric or psychological training."

- Few mental health professionals have been trained to work with the elderly (Lebowitz, Mental Health Policy & Aging, 1988). While the need for geriatric subspecialization has gained increased recognition, the

number of mental health clinicians, i.e., psychiatrists, psychologists, psychiatric social workers, psychiatric clinical nurse specialists, and psychiatric nurses who are willing or able to work with elderly nursing home residents is extremely small.

- Federal and State survey teams charged with determining facilities' continued participation in the Medicare and Medicaid programs rarely have specific experience working with geriatric populations and virtually never include licensed mental health professionals. Many providers are inhibited from implementing innovative or specialized approaches to mental health needs which may be misunderstood or misinterpreted by surveyors.

- Resident and family resistance to mental health intervention has also been a key factor in limiting the provision of these services. The stigma of mental illness remains particularly strong in the present population of the elderly nursing home residents, who tend to retain a stereotypic view which associates the need for this type of care with personal failure.

POSSIBLE SOLUTIONS

- Expand reimbursement for Medicare to include coverage for inpatient mental health services in non-psychiatric settings and eliminate the 190 cap on the life-time benefit.

- Add inpatient mental health services in non-psychiatric settings as a Medicaid benefit.

- Amend the IMD 50% Rule to include language such as that contained in Chairman Roybal's proposed legislation, H.R. 111, The Mental Health and Aging Act of 1989. This language would qualify that the fact that a facility provides mental health services or psychopharmacological drugs to residents who require the level of services provided by a nursing facility shall not be considered an indication that the facility is an IMD.

- Amend the IMD Determination Criteria as proposed by H.R. 111 to allow that the presence of staff members with specialized psychiatric or psychological training in a facility shall not be considered an indication that the facility is an IMD.

- Congress should retain the terminology active treatment in the MR/MI preadmission screening provisions of OBRA '87 to ensure that nursing facilities are not also charged with the role of caring for the acutely mentally ill, as currently assumed by IMDs and other psychiatric facilities. Congress should require that HCFA provide a detailed definition of the residents to be served under the statutory mandate for active treatment and what provision of these services will entail.

- Make available increased numbers of grants to: (1) support innovative

interventions for mental health programs in nursing facilities. Medicare and Medicaid are unlikely to include mental health services in reimbursement rates without some demonstration that the programs are efficacious and cost effective. Without this support, facilities will not have the resources to develop and test new interventions; and (2) foster affiliations between long-term care facilities and professional schools to provide exposure to geriatric mental illness and to afford facilities and residents greater access to services.

- Form a national task force composed of long-term care experts, Federal policy-makers, providers, consumer advocates, and geriatric mental health professionals to revisit and develop consensus on expectations for the provision of mental health services in nursing homes.

- Encourage the Department of Health and Human Services to engage in educational outreach activities which will dispell the myths and stereotypes associated with mental illness among the elderly.

CONCLUSION

Mr. Chairman and members of the Committee, I would like to thank you for the opportunity to present our views on this issue. We look forward to working with this Committee to meet our mutual goal of ensuring better mental health services to the elderly in our nation's nursing homes. I would be happy to answer any questions you may have.

QUESTIONS FOR **JOHN HOGAN**, REPRESENTING THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

1. You mention in your testimony that individuals with a primary and dominant diagnosis of mental illness do not belong in nursing homes. Could you elaborate on the reasons for your belief, as well as where they should be placed?

2. On page 13 of your statement, you briefly discuss your concern about proposed legislation that would delete the term active treatment in favor of language requiring the provision of specialized mental health services. You express the specific fear that this proposed language may result in a shift of the financial burden of providing services from the States to the nursing home. Would you please elaborate on this?

3. I am in strong agreement with your statement that Medicare and Medicaid are unlikely to include mental health services in reimbursement rates without some demonstration that the programs are effective and cost-efficient. Your program in Oregon has been identified as a successful model. What specifically in your program has led to your success, and how can we generalize your success to nursing homes across the country?

A A H A

August 24, 1989

The Honorable Edward R. Roybal, Chairman
Select Committee on Aging
U. S. House of Representatives
300 New Jersey Avenue, S.E.
House Annex 1, Room 712
Washington, DC 20515-6361

Dear Chairman Roybal:

The American Association of Homes for the Aging (AAHA) appreciates your continued efforts to ensure the provision of better mental health services to the elderly residents of our nation's nursing homes. On behalf of AAHA, we would also like to again thank the Committee for the opportunity to present our views on this issue at the August 3 Committee hearing.

As per your request of August 7, we are submitting the responses to the additional hearing questions.

QUESTION #1

WHY INDIVIDUALS WITH A PRIMARY/DOMINANT DIAGNOSIS OF MI DO NOT BELONG IN NURSING FACILITIES

As stated in our testimony, AAHA members agree that responding to the mental health needs of nursing home residents is critical to providing optimal quality care. However, our members have also overwhelmingly expressed the desire to retain the overall character of their facilities as nursing homes, and their primary function as providers of services to the elderly. As long-term care settings chiefly intended to serve the frail elderly, we are both poorly equipped and generally unable to meet the needs of persons who are acutely and chronically mentally ill.

For the past twenty years, nursing and/or medical needs of residents have been met through standards and practices based in the traditional medical model for care. Although that primary focus still exists, we have also come to recognize that virtually all of the physically disabling conditions common to our elderly residents have behavioral and mental health components which must be addressed, and that this must be accomplished outside a purely medical model. This is not to say, however, that all mental health services are the same. Unlike mental health facilities which are staffed and equipped on the premise that the primary care needs of

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residents will be psychiatric in nature, the staffing patterns and treatment modes available in nursing homes continue to reflect that it is the need for medical services that is the driving eligibility factor for admission. Because of this, nursing facilities lack the capability, particularly in terms of specialized staffing, to manage many of the behaviors and manifestations which are characteristic of major mental illnesses, or to respond adequately to persons in need of intensive, long-term psychotherapy.

Many nursing facilities do consult with mental health specialists on an as-needed basis. These mental health professionals work with staff and the resident to develop a plan of care which will respond to the resident's problem and which can be implemented by staff within the facility. In these instances, however, successful resolution is generally achieved with interventions of markedly less intensity and duration than those required by persons in an active psychotic state or other acute conditions. The capability of a nursing facility to address the mental health needs of its residents simply cannot be expected to equal the ability of a psychiatric facility to provide intensive and/or long-term psychiatric therapies and interventions. We believe that individuals with care needs resulting from a diagnosis of major mental illness would be better served through the therapies offered by an in-patient psychiatric facility, or when possible, in conjunction with community mental health programs.

QUESTION #2

ACTIVE TREATMENT VS. SPECIALIZED SERVICES

AAHA's reservation about the proposed change in nomenclature from active treatment to specialized services relates to our philosophy concerning the overall character and function of nursing facilities. The generic nature of this proposed change in terminology raises questions for us regarding: (1) the spectrum of services that are to be provided by a nursing facility —what services we will routinely be expected to provide; and (2) the characteristics of the residents we will routinely be expected to serve.

We have received little guidance from HCFA on the procedures governing the preadmission screening requirements. However, use of the term active treatment has developed significance as a term of art. As used by HCFA in the context of ICFs/MR, the definition is both limited and specific in terms of detailing the services to be included. We assume that application of this term to mental illness would also result in a description of specific services to be provided. We believe that a statutory mandate for the provision of specialized services may be interpreted by the Administration and/or States to require that nursing homes provide a broad array of psychiatric services to a much broader population, including the acutely mentally ill.

OBRA '87 mandates that States provide active treatment to those individuals determined to be in need of these services. Since there is no precedent for defining specialized services, as there is for active treatment, the determination of what services the State will be required to provide and

what will be considered standard nursing home practice, remains open to interpretation. Even within a diagnosis of major mental illness degrees of severity may be established. The result of implementing such generic terminology as specialized services may be ever-increasing expectations as to the acuity levels of mental illness which are to be managed in nursing homes. While the lack of reimbursement for mental health care under both the Medicare and Medicaid programs must certainly be considered in establishing the services to be provided, of major concern to us at this point is our fear that the nursing homes' mission of serving the needs of frail elderly will be compromised or lost if we are forced to try to provide all services to all people.

QUESTION #3

THE PROGRAM AT THE BENEDICTINE NURSING CENTER

We appreciate your interest in the program at the Benedictine Center and we are happy to identify some of the specific components we believe have contributed to its success.

- Emphasis on the Nursing Model for Care. Use of a primary nursing model places all accountability and responsibility for the resident's plan of care with the professional nursing staff. It relies on adequate RN coverage to ensure that each patient receives adequate attention.

- Use of Clinical Nurse Specialists. The Benedictine Center currently employs two full-time clinical nurse specialists (CNS), with respective concentrations in the areas of geriatrics and mental health. Both act as consultants to the nursing staff throughout the facility.

  The geriatric CNS helps to identify coexisting medical conditions, assists with the management of infections, skin care, problems with bowel and bladder functions, and pain management.

  The mental health CNS develops problem-solving processes related to problemmatic behaviors. When a resident exhibits a specific adverse behavior, the CNS works with the resident and staff to establish a plan of care which will respond appropriately to the behavior. The plan is then distributed to all staff so that response to the behavior will be consistent facility-wide. The mental health CNS also works to decrease the use physical and/or chemical restraints (approximately seven to eight percent of the Benedictine population receive anti-psychotic medications), and implements the SERVE Program—a specialized exercise program for people with Alzheimer's Disease and related dementias.

  Other mental health interventions implemented at the Benedictine Center are specifically directed at wandering behaviors. These include placing beds on low frames, use of ambu-alarms (alarms worn by the person and activated by wandering behavior), and use of "Code 10" which responds to a resident who has wandered away in the same manner as a fire alarm. Code 10 enables staff to alert the rest of the facility personnel that a resident may be missing so that the building and surrounding area may be checked immediately. We have also established guidelines for the use of psychotropic drugs and guidelines for RN

titration of medications, i.e., the physician provides the RN with a range for medication administration based on dosage and frequency and the RN applies his/her skills to determine appropriate use.

- o Training. All facility staff are trained in the care of the confused elderly.

- o Consultation Services. In addition to the CNS' on staff, the Benedictine Center frequently calls on both a gero-psychiatrist and a pharmacist for consultation on specific resident problems.

- o Academic Affiliations. The Benedictine Center has established affiliations not only with the Oregon Health Sciences University School of Nursing, but also with several local community colleges. Students from a variety of disciplines, including physical therapy, occupational therapy, speech therapy, activities, social services, and dietary regularly rotate through the facility. These arrangements for rotation provide the students with exposure and experience in geriatric care and enhance the services provided by the facility.

- o Interdisciplinary Team. The Benedictine Center has always employed an interdisciplinary team approach to the care of residents.

Thank you once again for your continued interest in this most important issue. AAHA looks forward to working with this Committee to ensure better mental health services to the elderly residents of our nation's nursing homes.

Sincerely,

John H. Hogan
Administrator
Benedictine Nursing Center
Mount Angel, Oregon

Michael F. Rodgers
Senior Vice President
Policy and Government Affairs

Mr. ROYBAL. Thank you, Mr. Hogan.

I would like to thank each member of the panel for your excellent testimony and recommendations that you have made.

I have, however, one other request, and that is that I have—and will make available to you—a summary of H.R. 111. I would greatly appreciate it if you would read it, study it, and then make recommendations as to how this bill can be improved. It is quite possible that we left some of the things out that you've recommended. And if we have, call it to our attention. We will rewrite the bill if it is necessary.

But we would like to present a bill that has the support of experts in the field. And we're not going to get that support if we leave out of that bill the very things that you're here to recommend. We would greatly appreciate it, then, if you would do that for the committee; and we can assure you that we will do everything possible to comply with the recommendations that you will make with regard to changes or any addition to this bill. A member of the staff will place before you a copy of the summary of H.R. 111.

I want to ask each and every one of you a question and each member of the committee will have time, then, to ask questions of each and every one.

Ms. Pacatte, you mentioned the use of community mental health programs to provide mental health care in nursing homes. I am interested in the community mental health program aspect. I was once in that field; not in mental health but in tuberculosis control, had programs in the community—and would like to know what your recommendation is with regard to community mental health programs to provide mental health care in nursing homes. Can you give us some specifics?

Ms. PACATTE. Yes, sir. As I mentioned in our written testimony and also in our oral testimony, we are of a unique situation, we do believe, in our particular county. Our mental health/mental retardation center comes in and provides their services on-site within the nursing home. As I did mention, it's mostly for those patients who are the most disruptive and the most dangerous to themselves or to other people.

They have provided that service to our county's nursing home residents. They have determined that to be a priority within our local community mental health service. As we have found, many community mental health centers have not found that to be a priority within their system. But within the last 5 to 10 years, we have also put that within the Texas State plan to provide for the elderly in the nursing homes.

Mr. ROYBAL. Dr. Smyer, you referred to financing of services as one of the barriers to involvement of mental health care professionals in nursing home care. Now, what suggestions do you have in the area of financing? And what do you think about nursing salaries?

Mr. SMYNER. Yes, let's start with that because that is something of great interest. Mr. Chairman, I should say that my mother was a nurse and some of my best friends are nurses, so they are clearly underpaid and overworked. But seriously, given the nursing shortage that we're experiencing nationwide, long-term care settings

have a real problem in trying to attract qualified nurses who are given more and more responsibility, particularly in the area of drug treatment and standing order PRN medications for residents with the range of problems that we've heard about this morning.

I think, on the other hand, the industry is in a difficult situation because it's being asked to attract staff at a time when it's going into a very competitive marketplace, not only for RNs but for LPNs, and also for nursing assistants, nurses aides who provide the majority of care. And they're trying to do that at a time when their own costs are escalating. And I'm sure my colleagues who are involved in direct service can provide—

Mr. ROYBAL. Dr. Smyner, the matter of salaries for nurses is not the only a barrier, is it? There are other financial barriers. What are they?

Mr. SMYNER. In terms of other disciplines, one of the financial barriers is just trying to provide a wage or a consulting fee that would be an incentive to get psychiatrists, psychologists, geriatric nurse practitioners into the setting.

In my written testimony I provide an indication of the low rate at which psychiatrists are paid for their consulting fees, for example. And, unfortunately, there are not a lot of settings that have colleagues like Barry Fogel and his colleagues providing consultation services underwritten by other funding streams. So that when you get into rural areas or areas without major academic settings, all of those core mental health disciplines currently have barriers for providing services in a consulting collaborative way.

And the settings that are providing leadership in this area often do so either through their own resources or through grants from other funding sources but not in the typical Federal funding streams.

Mr. ROYBAL. Thank you. Dr. Baldwin, I was concerned about a statement that you made on page 16 of your testimony in which you said that, "Of the 200-plus graduate programs in nursing listed in the National League for Nursing Directory for 1986, only five indicated the opportunity for specialization in geropsychiatric nursing."

Now, this is the statement that disturbs me: "even though psychiatric mental health nursing has been one of the most popular of the specialty areas in nursing for the last 20 years." What happened to that popularity? What is wrong with the program?

Dr. BALDWIN. I think you raise several important issues, Mr. Chairman. One thing is that geriatric nursing as a specialty apart from geriatric mental health nursing has certainly been one that's probably the most least attractive of all the specialty areas in nursing in the graduate program.

Our own experience at the University of Maryland, which is the largest School of Nursing in the country, is that we have the smallest number of graduate students in that particular specialty. Coupled with that is some of my comments regarding access to care and to direct services. People who specialize, nurses who specialize in geriatric mental health right now, unless they're nurse practitioners, are quite limited in their access to this population. In other words, the vision of going to work in a nursing home as either administrative personnel or a management person, or even a staff

nurse, is not very appealing to someone who has spent that much time in a graduate program.

I think it is a very important area that needs to be addressed because in my comments in the testimony, I have said that the attitudes toward the aging and toward geriatric mental health of health care professionals is a mirror of the attitudes of society. There's a great deal of bias against geriatrics and geriatric mental health among health care professionals generally—physicians, nurses, psychologists, social workers, and so forth. I think that's changing dramatically.

My optimism is that in the next 10 to 20 years we will have so many students trying to get into the specialty that we won't have all the resources that we need to assure that they can get trained and actually have the direct access to the patient population.

But right now, personally it's very hard for me to go out and market and advertise and try to get students into this specialty when I know the opportunities for their jobs are quite limited, particularly in long-term care.

Mr. ROYBAL. Thank you. Dr. Fogel, on page 13 of your testimony you said something to the effect that nursing homes have been receiving more care in recent years. I agree with that. I think they are administering more care than they did in the past, but not enough care. But then you went on to say, that "there are a number of areas that still need to be addressed."

"First," you said, "more data needs to be collected on the extent and types of behavioral and emotional disturbance prevalent in nursing homes." "This could be done," you said, "through the National Institute of Mental Health and the National Nursing Home Survey." Why hasn't it been done?

Is this something that the Congress can do? How can we get ourselves involved so that what you are suggesting here is done?

Dr. FOGEL. There's an issue at the level of detail involved. Any time one is doing a large survey, or epidemiological work of any kind, you can only cram a certain number of issues into one study.

If I'm going to go and look at people in a nursing home and I want to look at medication use, mental problems, physical problems, organization of care and so on, I can only look at so many things at one time. And when one has a more specialized question to answer, it's sometimes necessary to add an additional survey or to do more in-depth survey of a sub-population or—in other words, without interfering with the scientific judgment of the peer review committees that decide on who does research, and who contracts or gets grants, I think there's a question of Congress saying, we want to know about something.

I think that if Congress, for example, were interested in really understanding the problem of agitated behavior in nursing homes—which is why so many people get tranquilizers—it could ask NIMH or NIA, or the two of them together, to do something to look at agitated behavior and really, in a very deep way, take a large sample of the patients that are getting treated for agitated behavior and diagnose them properly and really work them up.

When you do a survey of a nursing home, you're talking about surveyors who on the whole are nonphysicians—you're talking about people who go out and do research in the field. They ask

questions of nurses, and they may use structured rating instruments, and so on—you're not talking about getting actual in-depth clinical evaluations on a sufficient number of people to get a thorough understanding of the problem.

So I guess the issue is, if we want to focus on that question, we ought to understand if we look at a problem like agitation, how does that break down in terms of people who have preexisting illnesses, people who have Alzheimer's disease, people who have problems adapting to nursing homes, and so on. That requires examining patients at a much greater level of detail than is going to be possible in a general purpose survey.

If it's something that Congress wants to know, I'm quite sure that my colleagues in NIMH and NIA are capable of commissioning a study to go after that information specifically, just as they are capable of funding drug research looking at frail, elderly people and the needs for behavioral treatments.

If you give an institute a pot of money, they are going to use it for the most scientifically meritorious work. If you want a specific area to be focused on, it's possible for Congress to let an institute know that some things are especially important, much as we've done with AIDS.

Mr. ROYBAL. Thank you.

Dr. Mays, I noticed in your statistics that it shows that only 5 percent of Indiana's nursing home population has a primary diagnosis of mental illness. This seems to be below other States. I think you'll remember in my opening statement I said this committee has reports that indicate that mental illness among nursing home patients are frequently undiagnosed, misdiagnosed, or diagnosed in such a manner that treatable disorders are not recognized. Where does the State of Indiana fall? The 5 percent seems to be below other States.

What is that due to? And is the rate of mental illness in Indiana lower in other age groups as well?

Mr. MAYS. First of all, I feel that Indiana is probably typical of the rest of the Nation in numbers. I think there are two reasons why our figures are lower than the other States. Number one, we have had preadmission screening in Indiana since 1983 and it has been practically impossible for a person with only a mental illness diagnosis to be admitted to a nursing facility; in other words, they had to have physical health diagnosis as well.

Additionally, we separate out Alzheimer's and dementias. They are mental disorders but they are not mental illnesses. So the 5 percent represents the major mental illnesses.

Mr. ROYBAL. Again, what happens to those people who may have a mental disorder of some kind—dementia or Alzheimer's—that are screened out but still may need care?

Mr. MAYS. In our OBRA process, as I indicated, so far of over 10,000 people that we have screened in the first 5 months of the program, only two people have actually been denied because of their mental health condition. And these people might be admitted to an inpatient unit at a community mental health center; they might be admitted to a State hospital; they might go into a private psychiatric facility—these types of things.

Mr. ROYBAL. My question really is, do they get taken care of? And if they do, the fact they've been screened out probably means that they've been screened to some other type of facility?

Mr. MAYS. That's correct, yes.

Mr. ROYBAL. Mr. Hogan, again going back to your testimony, on page 13 of your statement, you briefly discuss your concern about proposed legislation that would delete the term "active treatment" in favor of language that would require the provision of specialized mental health services. Would you explain to the committee what the difference is?

Mr. HOGAN. I think our concern in terms of the terminology "specialized services" is that, certainly from a mandated standpoint, somebody has to determine what those specialized services are, and who's going to pay for those services.

I think our concern is that when you use terminology like that, the expectations from the standpoint of regulatory agencies tend to expand. Therefore, the expectations of what the provider is to give in terms of services expand. And the overriding concern is where is the reimbursement for those services going to come from.

Mr. ROYBAL. The Chair recognizes Congressman Downey.

Mr. DOWNEY. Thank you, Mr. Chairman. I want to thank the panel for some really fine testimony. I think you have really given us a view of what the problems are and what some of the solutions are. But let me try to ask two quick questions and any member of the panel can answer.

If you had to make one change in Medicare, and you could make only one, what change would you make? Dr. Fogel.

Dr. FOGEL. I would recommend establishing parity of coverage for physical and mental disorders under Medicare. And I would add to that an even lower copayment than 20 percent for all medical services, including psychiatric services, that are rendered in a patient's home, in a nursing home, in a senior center, elderly housing, or any other community facility, to procreate positive incentives for providers to treat mental illness and also to go where the patients are and remove geographic barriers as well as financial barriers to access.

Mr. DOWNEY. It's a little bigger change in Medicare than I envisioned but it's certainly a good recommendation. Is there any disagreement by any member of the panel about the thrust of one thing in Medicare that we can change?

We've attempted to do this, of course, I mean, we've been able to move it incrementally, and we'll make another stab at it next year.

Dr. FOGEL. I'm specifically saying an incremental change that might make a very big difference and wouldn't cost all that much, is to reduce copayments for services rendered within nursing homes, because that's a relatively small population that has tremendous under-service.

Mr. DOWNEY. What about Medicaid? What change would be made in Medicaid?

Dr. FOGEL. Twofold, if I can pick that up. On Medicaid reimbursement for long-term care facilities, there should be a supplement—if you're not going for altogether case-mix based reimbursement, there should be a supplement to nursing facilities for taking on the care of people who have superimposed mental and behavior-

al problems in addition to a physical problem or disability that requires nursing facility placement. So that for the patient who is agitated or profoundly demented or needs a lot of supervision, there's an additional payment so that there's no fiscal disincentive to a facility to take that patient and offer adequate treatment.

On the provider side, Medicaid rates of reimbursement to mental health professionals for services in nursing homes should be competitive so people get in there and give the services.

Mr. DOWNEY. You are all, I hope, familiar with the change that we made in the Reconciliation this year which will provide reimbursement for qualified psychologists under Medicare. So we're moving in the right direction.

Ms. BALDWIN. I hope you keep moving, toward other providers, including psychologists, social workers, and nurses, too.

Mr. DOWNEY. Thank you, Mr. Chairman.

Mr. ROYBAL. The Chair recognizes Mr. Hughes.

Mr. HUGHES. I defer to Mr. Jontz.

Mr. ROYBAL. The Chair now recognizes Mr. Jontz and we'll come back to Mr. Hughes later.

Mr. JONTZ. Thank you, Mr. Chairman. I don't have any questions for the panel and I really do apologize that my schedule this morning has prevented me from hearing the testimony. But I did want to take a minute to say a word of thanks to Willard Mays from my State. I had a great deal of experience in the State legislature working with Willard.

I know he's doing an outstanding job in our Department of Mental Health. I appreciate him being here this morning to share with the committee some of his experiences in our State and also his recommendations.

I apologize again for not having heard the testimony but I do intend to study it and appreciate the willingness of all the witnesses this morning to help us, and appreciate in particular Willard's presence here and his good contribution. That's all I have, Mr. Chairman, thank you very much.

Mr. ROYBAL. Thank you. Mr. Hughes?

Mr. HUGHES. Thank you very much, Mr. Chairman. I want to, first of all, congratulate you, Mr. Chairman, and the chairman of the Human Services Subcommittee for convening this hearing and thank the panel for their testimony. I don't think that there are any areas that need more attention, really, than what we are discussing today. Over the last few years, I've spent more time in nursing homes than I'd like to think about. It's awfully depressing.

One of the things that concerns me, and I don't want to repeat what's already been said, is that the impact that those that have mental problems have on the rest of the resident population. I've been at nursing homes in the early morning hours when those with mental problems are screaming out, acting erratically, and it's a profound impact, it's sad.

There are so many people in nursing homes today because the type of care or service they require just does not exist in the community. Consequently, these nursing home residents are not receiving the kind of care often that they need, and that's the purpose of this hearing. We haven't developed really, the community base

services that are needed to deal with the myriad of problems that the elderly population has.

I wonder if anybody would like to comment on that? I'm talking about community base services like Alzheimer's care, adult day care, which is every bit as important to a senior's mental health as anything else; and other services that try to keep senior citizens in the mainstream of American life. Anyone?

Mr. SMYER. If I could just comment on that. I think it's clear that for every person in a nursing home, there are another two in the community who are equally impaired, and a large part of the difference is the availability of a range of supportive services in part provided by formal care providers, but the vast majority are provided by family and friends, and informal supports.

I think oftentimes the difference between the availability of those services, the availability of keeping someone out of the nursing home and inappropriate placement, oftentimes the difference is respite services or targeted support services that allow the family and friends to continue to be major service providers, supplementing but not supplanting the informal services provided by family and friends. Obviously, those informal services are not a substitute for professional treatment and care, but they are an important ancillary to that.

I think in the long run we need to do better at getting those formal services into the community. We know from research that when geriatric mental health is targeted as a service priority, community mental health centers do a better job at getting access for older adults in treating and successfully treating older adults. So we know we can do it if we make it a priority.

Dr. FOGEL. I can add to Dr. Smyer's comments. One of the reasons why families place people in nursing homes is because the person has some kind of behavior that the family can't tolerate; you know, like they're screaming at night, or they make incessant hypochondrical complaints, or they maybe strike somebody in the family, or they refuse to eat, or things like that. And that exceeds the family's tolerable burden of care.

Sometimes it's that the family caretaker themselves becomes depressed or develops a stress-related problem and gets overwhelmed by the burden of care. Now, I don't know what proportion this is. It would be nice to know with the right kind of study. But I would estimate at least one-third of the people who go into nursing homes go in, at least in large part, because there's been some kind of inadequately treated behavioral problem in the patient that has stressed the family, or that the family's ability to cope with and contain that problem has been exceeded.

I would like to see some linkage of the nursing home placement process with access to appropriate mental health services and diagnostic evaluation. If someone is being referred to a nursing home for the very first time, I think right at the outset it would be good to know, does this person suffer from a depression, is he paranoid, is the caretaker getting burnt out and depressed? Because there may be something you could do right there and then, that might be able to forestall that placement or enable the person to temporarily come in to the facility and then return to the community.

When people are mentally ill and untreated, they burn out everybody. They can't cooperate in their own care, they get their families fatigued, and then when they go in a nursing home they get the staff worn out too. Untreated mental illness is part of the reason that people wind up in nursing homes and its part of the reason there's a nursing assistant shortage.

I think we should link access to mental health services to the placement process, and not wait until the person's been there for 90 days, and on tranquilizers, and some surveyor comes around and says, gee, maybe you ought to have a diagnosis.

Mr. HUGHES. Doctor, I think you make some valid points.

The point that I was attempting to make is that we do have a serious problem in providing treatment for those that either had mental problems when they went into the nursing home, or developed mental problems in the nursing home either because of the drugs that they are administered—which often creates erratic behavior—or because with a deteriorating physical ailment they develop mental problems in connection with it. Some of the testimony today suggests that.

I think that your estimate of the number in nursing homes that have behavioral problems is very conservative. I suspect it's more than that. The population with some form of mental illness is negatively impacting the population that does not, and it's a serious problem.

I have seen it firsthand. Even before I came to the Congress, I spent a lot of time in nursing homes caring for elderly residents from my area that had no one else to care for them. And, frankly, I've seen it over the years and it seems to be getting worse, not better.

Dr. FOGEL. One untreated case of agitated depression can basically ruin the environment in an entire wing of a nursing home. Someone's yelling out, "help me, help me, help me," 36 hours a day. Even though they have a treatable mental disorder, they won't get treatment for it. You're absolutely right. It impacts on all of this problem—the morale of the others as well as the ability to recruit and retain staff.

Mr. HUGHES. A member of our family was in a nursing home about a year ago, and I can't begin to tell you the number of times we had to move her because of the impact that somebody who had mental problems was having on her and the whole wing. You're absolutely right, I couldn't agree with you more.

Dr. BALDWIN. I think also, Mr. Hughes, when nursing homes began to be conceptionalized as therapeutic facilities that are part of a whole range of community services for the elderly, I think we're going to see a very different way of handling some of these problems.

For example, right now most people, whether they want to admit it not, see nursing homes—and I will use that term—as warehouses, last stops. Staff say to me this is hospice care but you don't call it hospice care. It's sort of the end of the line. They don't see people coming into nursing homes, those even who are severely mentally ill, with the potential of going out every day and spending their day in a day care center, and coming to the nursing home at night.

In the case of some of the people we've worked with, they've been in the nursing home for a while, they have a lot of supervision, they have a chance to really do well on medications; now they're going to go out into a less confining environment—that thinking of a nursing home as a therapeutic environment rather than a custodial one.

I think until we change some of those attitudes, get a whole array of services in there to really change that around, we're going to have exactly what you've seen in the past continue in the future.

Mr. HUGHES. The only place I disagree with you is that I think that nursing homes, unfortunately, have been a repository of last resort for all kinds of problems because we have failed as we deinstitutionalize to develop a broad network of community base services to deal with a myriad of problems. So the nursing home is looked upon as a place of last resort.

Dr. BALDWIN. I agree with you. And I think what happens is sort of the self-fulfilling prophecy if that's what you expect of that environment and that's the attitude about that environment, that's what happens.

If it's considered to be one of many different community resources that are available, including adult day care, senior centers, home health care, then you look at it differently—where does the person fit in at any one point in time, including those that are severely frail or dysfunctional. Many of those people can function well in other environments. But we haven't really had the opportunity to see that.

I agree with your comments exactly. We spent many hours in nursing homes and all hours of the day and night. And you're absolutely right, the impact of people who have severe behavioral problems on those who do not is overwhelming. I don't know that I could stay in many of those settings very long without taking on some of the behavior. And I think sometimes that's what we see.

Mr. HUGHES. The data shows that people live in nursing homes an average of 18 months. Mr. Hogan.

Mr. HOGAN. Yes, just one comment.

Basically I agree with the panel in the sense that the direction towards a restorative program that encompasses all aspects of the person is really where long-term care needs to go.

I do feel that when academia and the health professionals in this country begin to recognize that long-term care has a proper place in the continuum of care, then the rest of the country will begin to realize it has a rightful role in that continuum of care.

When we talk about nurses not being willing to go into long-term care it really is the nursing schools that have played a large part in that. I think until we get the faculty interested we will not have the interest of the students—and we had the same experiences in Oregon when we started out with Oregon Health Sciences University. The lack of interest on the part of students to get into geriatric nursing was really fostered by the faculty. It was not until the faculty became really understanding of the site, in terms of the practice, that students began to develop an interest.

We now have to turn away students related to our mental health program. In the past, we had to beg students to come into that program. I think there are some changes taking place.

Mr. HUGHES. Mr. Chairman, I know my time is up. You have been very indulgent. I just have one more comment for Dr. Fogel.

On page 13 of your statement, you suggest that consideration should be given to raising the effective reimbursement rates for medical services in nursing homes to encourage physicians—including psychiatrists—to see more nursing home patients. I think we have to do that.

But I would hope also that individuals such as yourself, and groups such as the American Psychiatric Association, and others working within your profession, will visit more nursing homes and do more just because it's the right thing to do.

Dr. FOGEL. I can say that in the area where I have some control is my own institution, every psychiatry resident at Brown University treats elderly patients and physically ill patients, and Alzheimer's patients. And even if they say they're going to specialize in psychotherapy with children, they still do it. As a result, sometimes people who didn't come to Brown thinking that they were going to do that kind of work, will do it. I still do feel that for people outside of academic settings, reimbursement and related incentives do make a difference.

And the other thing that makes a difference, as you say, is modeling. To the extent that incentives can be offered under the Medicare medical education support programs to positively encourage training programs in all areas in teaching hospitals to provide exposure to this patient population, I think that's really going to help. Exposure sometimes will get people involved.

If I may just talk a minute about something that came to mind while you were asking your other question about nursing. One simple thing is to consider is taking mental problems into account in deciding whether a patient is eligible for the Medicare skilled nursing facility benefit. Right now, Medicare SNF benefits are seen as largely for very narrowly physical rehabilitative needs. If the Medicare SNF benefit could be expanded to include those kind of temporary but severe mental and behavioral problems that might respond to a more skilled and intensive nursing intervention with appropriate consultation, this might create a new way of using an existing program to, say, help the elderly person who's temporarily impaired because of a reactive depression or that sort of thing.

Mr. HUGHES. Thank you. Thank you, Mr. Chairman.

Mr. MAYS. Mr. Chairman, an item I'd like to throw in. Two items that I think are very important that I have not heard addressed today is the need for coordination between our various service delivery systems and governmental agencies, because we're dealing with whole persons here, not just a particular disability. These people have more than one problem, and it's both mental and physical. There needs to be a way where public health, mental health, aging services, et cetera, can work more effectively together.

Secondly, I haven't heard anyone mention today the whole issue of effective discharge planning. I personally went through this a couple of years ago when my mother was hospitalized with terminal cancer. When it came time for her to be discharged from the

acute care hospital, the only option that was given to me was to place her in a nursing home. Because I was a professional in the field, I was aware of lots of other alternatives that existed, and I was able to keep her at home for a short period of time by tapping into community services that were available.

So I would emphasize the need to take a look at discharge planning in acute care hospitals and also in nursing facilities because not everyone who goes into a nursing facility has to remain there for the rest of their life.

Mr. ROYBAL. Mr. Mays, I thank you for your suggestions. It's something that this committee would definitely look at. Again, going back to my mental health and aging legislation, H.R. 111, after you review it, I hope you will make specific recommendations, such as the recommendations that Mr. Mays has just made.

I would like to thank each and every one of you for your testimony. We have another witness we would like to hear. And I hope that this will round off the program as a whole so that we can proceed with the proper legislation. Thank you very much.

Dr. Ross Anthony. Dr. Anthony, you may proceed in any manner that you may desire.

STATEMENT OF C. ROSS ANTHONY, PH.D., ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION

Mr. ANTHONY. Thank you, Mr. Chairman. I'd like my statement submitted for the record and I'd like to read a much abbreviated one, if I may.

Mr. ROYBAL. We thank you for that, and without objection, it will be the order.

Mr. ANTHONY. Mr. Chairman and members of the committee, I am pleased to be here today to discuss the role of the Medicare and Medicaid programs in the financing of health services for older Americans with mental illnesses. We share your concerns for this vulnerable group, and are pleased to report that the Federal and State programs are responding to them.

There are two aspects of the Medicare and Medicaid programs that should be emphasized before I begin a discussion of mental health coverage under them. First, these programs, like private insurance, both originated based upon an acute care medical model and are heavily weighted in that direction even though additional benefits have been added over time. Second, benefits under the programs are generic rather than disease-specific, so that a discussion of mental health coverage is largely an extrapolation from the general coverage provisions of the law. These two factors help explain why gaps in mental health coverage, where they appear, are often generic gaps in coverage that, in fact, go beyond the boundaries of mental health.

In the Medicare program, which is the primary payer for individuals over the age of 65, the program covers physician services and in-patient hospital services in general hospitals for an unlimited number of total days per year. Medicare also covers up to 150 days a year of care in a skilled nursing facility—SNF. This care may include mental health care needed by the patient. In fact, under the

new nursing home reform requirements of the Omnibus Budget Reconciliation Act of 1987—OBRA 87—a SNF is required to meet the psycho-social needs of any patient it admits.

Medicare provides coverage of mental health benefits in additional ways. One of the most useful benefits under Part B, in terms of providing mental health care, is the out-patient hospital services benefit. A wide variety of services are available in these settings for treatment of mental disorders, including individual and group therapy, diagnosis, patient training and education, occupational therapy, social work, psychiatric nursing, and family therapy.

In fact, HCFA issued instructions relating to these services several years ago in order to assist hospitals in developing programs for which payment could be made. Our instruction was incorporated in OBRA '87 as a partial hospitalization benefit. These partial hospitalization benefits are not subject to the out-patient dollar limit or to a limit on days of treatment as long as the treatment is medically necessary.

The Medicare law also emphasized that benefits for the mentally ill be used for medical treatment rather than simply long-term custodial care. For this reason, benefits in psychiatric hospitals have been limited by statute since the inception of the Medicare program. The limit has been increased several times but now stands at 190 days of psychiatric hospital in-patient care in a lifetime. A statutory limit has also been set on the dollar amount of mental health services available each year on an out-patient basis which has been increased significantly by OBRA '87.

The Medicaid program is the primary payer of health care services for the elderly and disabled with low incomes. This is a joint Federal and State effort with certain federally-required eligibility groups and services and broad discretion for States to opt to include other eligible groups and services in designing programs that best meet the unique needs of their residents.

Among the mandatory Medicaid services relevant to our discussion today, mental health services can be provided through in-patient and out-patient services in general hospitals, in skilled nursing facilities and in rural health clinics. Physician services are also mandatory and can include the services of psychiatrists as well as other specialists.

In addition to the mandatory services, States can choose to offer a number of other optional services that can be used in varying ways to structure a comprehensive package of services for the mentally ill. Such optional services include prescription drugs, clinical services, rehabilitation services, other practitioners' services, personal care services, and case management.

The flexibility built into our regulations means that States offering services under these optional benefits may do so in a variety of ways. However, the widespread use of benefits by States does not mean that there is not much more that could be done under current law. In fact, it is likely that most of the ambulatory mental health care needed could be provided by State Medicaid programs taking fuller advantage of these options presently available to them.

Medicaid patients in nursing homes receive medically necessary mental health services which are included in the State-set nursing

home per diem rate or are paid directly to a physician for professional services. Unlike Medicare, Medicaid does not limit the number of days of nursing facility care, as long as it is medically necessary.

There's one area in which the Medicaid statute contains no coverage for the mentally ill. That is with respect to institutional care for individuals between the ages of 22 and 65 who are patients in institutions for mental diseases—IMDs. Since the inception of the Medicaid program, there has been an IMD exclusion, as I know you are well aware. Its original purpose was to assure that Medicaid funds were not used to offset traditional State expenditures on behalf of the mentally ill in institutions. The exclusion has been modified over time to permit Medicaid payment for services to individuals under the age of 22 and age 65 and over. However, the IMD exclusion continues to stand for persons between the ages of 22 and 64. While the purpose of this exclusion has more to do with the issue of who should fund services than what services are appropriate, it has had the effect of encouraging deinstitutionalization and the use of less intensive settings.

A provision included in the Medicare Catastrophic Coverage Act has further encouraged this trend by redefining the term IMD to exclude facilities with 16 beds or less.

Of course, most hospitals, nursing facilities, and other residential facilities would not be classified as IMDs. In those that are not, Medicaid pays for medically necessary care, including mental health care, for eligible patients or residents, regardless of age.

Because Medicaid funds are available for care in a nursing home facility, but generally are not available for care in a facility that is an IMD, there has been concern among mental health professionals, advocates, and others that financial incentives might led to inappropriate placement of some mentally ill persons in nursing facilities. Congress responded to these and other concerns by including a comprehensive package of nursing home reforms in OBRA '87. This is a very important change. Among these reforms are requirements for preadmission screening and annual resident review—referred to as PASARR.

Mr. Chairman, I know that you and other members of the committee are concerned with improving services to persons with Alzheimer's disease. We share your concern. In previous testimony, you heard from the National Institute of Mental Health about the Department's research efforts on Alzheimer's disease and related conditions. I would like to add a few words to clarify how the nursing home reform provisions will affect those with Alzheimer's disease in nursing facilities.

Persons with Alzheimer's disease and other dementias, who are believed to be a majority of those with mental conditions in nursing homes, are not considered mentally ill and, therefore, would not be subject to preadmission screening or annual reviews. This does not mean that they will not be appropriately served. On the contrary, they, like all other nursing facility residents, will receive necessary mental health, psycho-social, and other services under an individualized plan of care that's required under the regulations.

The Medicare and Medicaid programs now provide more and better ways to finance medically necessary services for the mental-

ly ill than they ever have before. They pay for the costs of in-patient intervention for acute episodes coupled with flexible options for out-patient care on an ongoing basis. These practices reflect both provider and community consensus of the most effective and appropriate treatment approaches currently available.

We are committed to working with the States, the Congress, and the private sector to ensure that the Medicare and Medicaid programs continue to make a significant and effective contribution to improve the services that we, in fact, are providing to older persons who are mentally ill.

With that I would be glad to answer any questions that you may have.

[The prepared statement and supplemental material submitted by Mr. Anthony follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

C. ROSS ANTHONY, Ph.D.

ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE
SELECT COMMITTEE ON AGING
AND THE
SUBCOMMITTEE ON HUMAN SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

AUGUST 3, 1989

INTRODUCTION

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. I AM PLEASED TO BE HERE TODAY TO DISCUSS THE ROLE OF THE MEDICARE AND MEDICAID PROGRAMS IN HELPING TO FINANCE HEALTH SERVICES FOR OLDER AMERICANS WITH MENTAL ILLNESS. WE SHARE YOUR CONCERNS FOR THIS VULNERABLE GROUP, AND ARE PLEASED TO REPORT THAT FEDERAL AND STATE PROGRAMS ARE RESPONDING TO THEM. IN FISCAL YEAR 1987, OVER $1 BILLION IN MEDICAID FUNDS WENT TO MENTAL INSTITUTIONS, WHILE ADDITIONAL FUNDS WERE USED TO PROVIDE SERVICES FOR THE MENTALLY ILL IN ORDINARY HOSPITALS, NURSING HOMES AND IN THE COMMUNITY. MEDICARE IS ESTIMATED TO HAVE SPENT A TOTAL OF $2.2 BILLION FOR PART A AND B MENTAL HEALTH BENEFITS IN 1987, INCLUDING $1.6 BILLION FOR IN-PATIENT MENTAL HOSPITAL SERVICES, $253 MILLION FOR MENTAL HEALTH SERVICES FURNISHED BY PSYCHIATRISTS AND INDEPENDENT PSYCHOLOGISTS, AND THE REMAINING AMOUNT FOR SERVICES BY OTHER PHYSICIANS, NURSING FACILITIES, AND OUT-PATIENT MENTAL HEALTH SERVICES.

THERE ARE TWO ASPECTS OF THE MEDICARE AND MEDICAID PROGRAMS THAT SHOULD BE EMPHASIZED BEFORE I BEGIN A DISCUSSION OF MENTAL HEALTH COVERAGE UNDER THEM. FIRST, THESE PROGRAMS, LIKE PRIVATE HEALTH INSURANCE, BOTH ORIGINATED BASED UPON AN ACUTE CARE MEDICAL MODEL AND ARE HEAVILY WEIGHTED IN THAT DIRECTION EVEN THOUGH ADDITIONAL BENEFITS HAVE BEEN ADDED OVER TIME.

SECOND, BENEFITS UNDER THE PROGRAMS ARE GENERIC RATHER THAN DISEASE-SPECIFIC, SO THAT A DISCUSSION OF MENTAL HEALTH COVERAGE UNDER THE BENEFITS (EXCEPT FOR SUCH SPECIFIC SERVICES AS PSYCHIATRIC HOSPITAL SERVICES) IS AN EXTRAPOLATION FROM THE GENERAL COVERAGE PROVISIONS OF THE LAW. THESE TWO ASPECTS OF THE PROGRAMS GIVE RISE TO SOME OF THE ANOMALIES IN MENTAL HEALTH COVERAGE THAT EXIST, AND BY KEEPING THEM IN MIND IT IS POSSIBLE TO UNDERSTAND THAT GAPS IN MENTAL HEALTH COVERAGE, WHERE THEY APPEAR, ARE OFTEN GENERIC GAPS IN COVERAGE THAT GO WELL BEYOND MENTAL HEALTH.

MEDICARE

THE MEDICARE PROGRAM IS THE PRIMARY PAYOR OF HEALTH CARE FOR INDIVIDUALS OVER AGE 65. THE PROGRAM COVERS PHYSICIAN SERVICES, WHETHER THEY ARE PROVIDED BY A SURGEON, AN INTERNIST, OR A PSYCHIATRIST. SIMILARLY, MEDICARE CAN NOW PAY FOR IN-PATIENT HOSPITAL SERVICES IN A GENERAL HOSPITAL FOR AN UNLIMITED NUMBER OF TOTAL DAYS PER YEAR, WHETHER THE PATIENT IS ADMITTED TO A SURGICAL, GENERAL MEDICAL, OR PSYCHIATRIC UNIT OF SUCH A HOSPITAL. EACH ADMISSION MUST BE MEDICALLY NECESSARY AND PAYMENT IS BASED ON DIAGNOSTIC RELATED GROUPS, WHICH INCLUDE SEVERAL PSYCHIATRIC DIAGNOSES.

MEDICARE ALSO COVERS UP TO 150 DAYS A YEAR OF CARE IN A SKILLED NURSING FACILITY. THIS CARE MAY INCLUDE MENTAL HEALTH CARE NEEDED BY THE PATIENT. IN FACT, UNDER THE NEW NURSING HOME REFORM REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA 87), A SNF IS REQUIRED TO MEET THE PSYCHO-SOCIAL NEEDS OF ANY PATIENT IT ADMITS. HOWEVER, THE LAW DOES BAR SNFS THAT ARE INSTITUTIONS FOR MENTAL DISEASES FROM PARTICIPATING IN THE MEDICARE PROGRAM. THIS MEANS THAT FACILITIES SPECIALIZING IN PSYCHIATRIC TREATMENT MAY NOT RECEIVE MEDICARE PAYMENT AS SNFS AND IT REFLECTS (WE BELIEVE) A CONGRESSIONAL VIEW THAT THE SNF BENEFIT IS NOT INTENDED TO BE PRIMARILY A MENTAL HEALTH BENEFIT.

MEDICARE PROVIDES COVERAGE OF MENTAL HEALTH BENEFITS IN ADDITIONAL WAYS. THE STATUTE WAS CLARIFIED TO MAKE EXPLICIT THE COVERAGE OF PSYCHOLOGISTS SERVICES AS PART OF IN-PATIENT HOSPITAL CARE. IN ADDITION, THE SERVICES OF PSYCHIATRISTS AND OTHER PHYSICIANS MAY BE COVERED SEPARATELY FROM INSTITUTIONAL SERVICES UNDER MEDICARE PART B. COVERAGE OF THE SERVICES OF CLINICAL SOCIAL WORKERS AND NURSE PRACTITIONERS IS NOW PROVIDED IN RISK-SHARING HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS. DIRECT PAYMENT OF CLINICAL PSYCHOLOGISTS IN RURAL HEALTH CLINICS IS NOW PROVIDED AND SHOULD REDUCE DIFFICULTIES THAT BENEFICIARIES IN RURAL AREAS HAVE EXPERIENCED IN OBTAINING MENTAL HEALTH SERVICES.

WHILE PSYCHOLOGISTS PRACTICING INDEPENDENTLY CANNOT NOW BILL MEDICARE DIRECTLY, 1990 BUDGET RECONCILIATION PROVISIONS APPROVED RECENTLY BY BOTH THE HOUSE WAYS AND MEANS AND ENERGY AND COMMERCE COMMITTEES WOULD PERMIT SUCH DIRECT PAYMENT OF CLINICAL PSYCHOLOGISTS.

ONE OF THE MOST USEFUL BENEFITS UNDER PART B, IN TERMS OF PROVIDING MENTAL HEALTH CARE, IS THE OUT-PATIENT HOSPITAL SERVICES BENEFIT. A WIDE VARIETY OF SERVICES ARE AVAILABLE IN THESE SETTINGS FOR TREATMENT OF MENTAL DISORDERS. IN FACT, HCFA ISSUED INSTRUCTIONS RELATING TO THESE SERVICES SEVERAL YEARS AGO IN ORDER TO ASSIST HOSPITALS IN DEVELOPING PROGRAMS FOR WHICH PAYMENT COULD BE MADE. OUR INSTRUCTION WAS INCORPORATED IN OBRA 87 AS A PARTIAL HOSPITALIZATION BENEFIT.

THIS BENEFIT, WHICH WAS ALREADY BEING PROVIDED WHEN THE OBRA PROVISION WAS ENACTED, PROVIDED FOR DAY TREATMENT OF LESS THAN 24-HOUR AMBULATORY CARE IN A HOSPITAL-BASED OR AFFILIATED OUT-PATIENT PROGRAM.

PARTIAL HOSPITALIZATION COVERS A BROAD ARRAY OF SERVICES WHICH CAN BE COMBINED INTO PACKAGES TO MEET THE UNIQUE NEEDS OF DIFFERENT MENTALLY ILL PERSONS. FOR EXAMPLE, A BENEFICIARY CAN RECEIVE INDIVIDUAL AND/OR GROUP THERAPY BY PSYCHIATRISTS, PSYCHOLOGISTS, AND OTHER STATE-LICENSED MENTAL HEALTH PERSONNEL.

THE BENEFICIARY CAN ALSO RECEIVE DIAGNOSTIC SERVICES, TRAINING AND EDUCATION, AND OCCUPATIONAL THERAPY. IN ADDITION, NON-SELF-ADMINISTERED DRUGS AND THE SERVICES OF SOCIAL WORKERS AND TRAINED PSYCHIATRIC NURSES CAN BE PROVIDED. THESE SERVICES, WHICH ARE INTENDED TO HELP MAINTAIN AND IMPROVE FUNCTIONING OF THE MENTALLY ILL INDIVIDUAL IN THE COMMUNITY, CAN BE SUPPLEMENTED WITH COUNSELING FOR THE INDIVIDUAL'S FAMILY TO HELP THEM RESPOND TO THE STRESSES OF COPING WITH THEIR FAMILY MEMBER'S ILLNESS. THESE PARTIAL HOSPITALIZATION SERVICES ARE NOT SUBJECT TO THE OUTPATIENT DOLLAR LIMIT OR TO A LIMIT ON DAYS OF TREATMENT, AS LONG AS THE TREATMENT IS MEDICALLY NECESSARY.

IN KEEPING WITH THE LONG-STANDING AND WIDELY-HELD CONSENSUS AMONG MENTAL HEALTH EXPERTS, THE MEDICARE LAW HAS ALWAYS EMPHASIZED THAT BENEFITS FOR THE MENTALLY ILL BE USED FOR MEDICAL TREATMENT RATHER THAN SIMPLY LONG-TERM, CUSTODIAL CARE. FOR THIS REASON, BENEFITS IN PSYCHIATRIC HOSPITALS HAVE BEEN LIMITED, BY STATUTE, SINCE THE INCEPTION OF THE MEDICARE PROGRAM. THAT LIMIT HAS BEEN INCREASED SEVERAL TIMES AND NOW STANDS AT 190 DAYS OF PSYCHIATRIC HOSPITAL IN-PATIENT CARE IN A LIFETIME.

A STATUTORY LIMIT HAS ALSO BEEN SET ON THE DOLLAR AMOUNT OF MENTAL HEALTH SERVICES AVAILABLE EACH YEAR ON AN OUT-PATIENT BASIS. THIS LIMIT WAS INCREASED SIGNIFICANTLY BY OBRA 87, AND WOULD BE REMOVED ENTIRELY UNDER PROVISIONS APPROVED LAST MONTH FOR INCLUSION IN THE FY 1990 HOUSE BUDGET RECONCILIATION BILL.

BEGINNING JANUARY 1, 1991, THE MEDICARE CATASTROPHIC COVERAGE ACT PRESCRIPTION DRUG BENEFIT WILL COVER PSYCHOTROPIC AS WELL AS OTHER TYPES OF PRESCRIPTION MEDICATIONS USED ON A CONTINUING BASIS.

MEDICAID

THE MEDICAID PROGRAM IS THE PRIMARY PAYOR OF HEALTH CARE SERVICES FOR ELDERLY AND DISABLED PERSONS WITH LOW-INCOMES. WHILE MEDICARE IS A FEDERAL PROGRAM WITH UNIFORM ELIGIBILITY AND COVERAGE RULES NATIONWIDE, MEDICAID IS A JOINT FEDERAL-STATE EFFORT WITH CERTAIN FEDERALLY-REQUIRED ELIGIBILITY GROUPS AND SERVICES. MEDICAID PROVIDES BROAD DISCRETION FOR STATES TO OPT TO INCLUDE OTHER ELIGIBILITY GROUPS AND SERVICES IN DESIGNING PROGRAMS TO BEST MEET THE UNIQUE NEEDS OF THEIR RESIDENTS.

AMONG THE MANDATORY MEDICAID SERVICES RELEVANT TO OUR DISCUSSION TODAY, MENTAL HEALTH SERVICES CAN BE PROVIDED THROUGH IN-PATIENT AND OUT-PATIENT SERVICES IN GENERAL HOSPITALS AND IN SKILLED NURSING FACILITIES. MENTAL HEALTH SERVICES CAN ALSO BE PROVIDED IN THE HOME AS SKILLED NURSING CARE, AND IN RURAL HEALTH CLINIC SETTINGS BY A VARIETY OF PROVIDERS. PHYSICIAN SERVICES ARE ALSO MANDATORY AND CAN INCLUDE THE SERVICES OF PSYCHIATRISTS AS WELL AS OTHER SPECIALISTS. RATES OF PAYMENT FOR ALL OF THESE DIFFERENT TYPES OF PROVIDERS ARE SET BY THE STATES IN ACCORDANCE WITH STATUTORY AND REGULATORY GUIDELINES.

IN ADDITION TO THE MANDATORY SERVICES, STATES CAN CHOOSE TO OFFER A NUMBER OF OTHER, OPTIONAL SERVICES THAT CAN BE USED IN VARYING WAYS TO STRUCTURE A COMPREHENSIVE PACKAGE OF SERVICES FOR THE MENTALLY ILL. A PRESCRIPTION DRUG BENEFIT (NOW OFFERED IN ALL STATES) CAN PAY FOR PSYCHOTROPIC MEDICATIONS. CLINIC SERVICES (OFFERED BY ALL BUT 3 STATES) AND/OR REHABILITATION SERVICES (OFFERED BY 36 STATES) CAN PROVIDE DAY TREATMENT, COUNSELING AND VARIOUS KINDS OF THERAPY. OTHER PRACTITIONERS' SERVICES (OFFERED BY 35 STATES) PERMIT STATES TO PAY FOR THE SERVICES OF A RANGE OF PROVIDERS LICENSED UNDER THEIR STATE LAWS, INCLUDING SOCIAL WORKERS, PSYCHOLOGISTS, AND THERAPISTS OF VARIOUS KINDS. PERSONAL CARE SERVICES (25 STATES) ARE AVAILABLE FOR MEDICAL SERVICES THAT ASSIST RESIDENTS TO FUNCTION BETTER IN THEIR HOMES AND CASE MANAGEMENT SERVICES (26 STATES) CAN LINK THEM TO SERVICES AT OTHER LOCATIONS.

THE FLEXIBILITY BUILT INTO OUR REGULATIONS MEANS THAT STATES OFFERING SERVICES UNDER THESE OPTIONAL BENEFITS MAY DO SO IN A VARIETY OF WAYS. HOWEVER, THE WIDESPREAD USE OF THESE BENEFITS BY STATES DOES NOT MEAN THAT THERE IS NOT MUCH MORE THAT COULD BE DONE UNDER CURRENT LAW. IN FACT, IT IS LIKELY THAT MOST OF THE AMBULATORY MENTAL HEALTH CARE NEEDED COULD BE PROVIDED BY STATE MEDICAID PROGRAMS TAKING FULLER ADVANTAGE OF THE OPTIONS PRESENTLY AVAILABLE TO THEM. RECENT LEGISLATION PROVIDED FURTHER STATE FLEXIBILITY BY PERMITTING THEM TO PROVIDE MEDICAID SERVICES TO HOMELESS INDIVIDUALS IN VARIOUS NON-TRADITIONAL SETTINGS.

STATES MAY REQUEST WAIVER OF CERTAIN OTHER MEDICAID REQUIREMENTS IN ORDER TO CONDUCT SPECIAL PROJECTS TO BETTER MEET THE NEEDS OF CERTAIN POPULATIONS. FOR EXAMPLE, THE MEDICAID HOME AND COMMUNITY-BASED WAIVER PROGRAM ALLOWS STATES TO PROVIDE CERTAIN SERVICES FOR PERSONS WHO ARE AT RISK OF INSTITUTIONAL CARE. STATES CAN TAILOR ELIGIBILITY AND SERVICE COVERAGE TO THE TARGET POPULATION (SUCH AS THE FRAIL ELDERLY, THE LONG-TERM DISABLED, AND THE CHRONICALLY MENTALLY ILL, IN CERTAIN GEOGRAPHIC AREAS OF THE STATE) WITHOUT BEING REQUIRED (AS UNDER THE USUAL MEDICAID RULES) TO PROVIDE THE SAME SERVICES TO OTHER MEDICAID ELIGIBLES THROUGHOUT THE STATE. FOR THE ELDERLY WHO ARE MENTALLY ILL, SERVICES UNDER A WAIVER MIGHT INCLUDE CASE MANAGEMENT, HABILITATION, PERSONAL CARE, HOMEMAKER, ADULT DAY CARE, RESPITE CARE, AND TRANSPORTATION.

MEDICAID PATIENTS IN NURSING FACILITIES ALSO RECEIVE MEDICALLY NECESSARY MENTAL HEALTH SERVICES WHICH ARE INCLUDED IN THE STATE-SET NURSING HOME PER DIEM RATE OR ARE PAID DIRECTLY TO A PHYSICIAN (INCLUDING A PSYCHIATRIST) FOR PROFESSIONAL SERVICES. UNLIKE MEDICARE, MEDICAID DOES NOT LIMIT THE NUMBER OF DAYS OF NURSING FACILITY CARE, AS LONG AS IT IS MEDICALLY NECESSARY.

THERE IS ONE AREA IN WHICH THE MEDICAID STATUTE CONTAINS NO COVERAGE FOR THE MENTALLY ILL. THAT IS WITH RESPECT TO INSTITUTIONAL CARE FOR INDIVIDUALS BETWEEN THE AGES OF 22 AND 65 WHO ARE PATIENTS IN INSTITUTIONS FOR MENTAL DISEASES (IMDS).

SINCE THE INCEPTION OF THE MEDICAID PROGRAM, THERE HAS BEEN AN "IMD EXCLUSION." ITS ORIGINAL PURPOSE WAS TO ASSURE THAT MEDICAID FUNDS WERE NOT USED TO OFFSET TRADITIONAL STATE EXPENDITURES ON BEHALF OF THE MENTALLY ILL IN INSTITUTIONS. THE EXCLUSION HAS BEEN MODIFIED OVER TIME TO PERMIT MEDICAID PAYMENT FOR SERVICES TO INDIVIDUALS UNDER THE AGE OF 22 AND OVER THE AGE OF 65. (MEDICAID CAN PAY FOR IMD CARE FOR INDIVIDUALS AGE 65 AND ABOVE IN PSYCHIATRIC HOSPITALS AND/OR NURSING FACILITIES, IF THE STATE OPTS TO INCLUDE SUCH FACILITIES IN ITS MEDICAID PROGRAM.) HOWEVER, THE IMD EXCLUSION CONTINUES TO STAND FOR PERSONS AGED 22 TO 64. WHILE THE PURPOSE OF THIS EXCLUSION HAS MORE TO DO WITH THE ISSUE OF WHO SHOULD FUND SERVICES THAN WHAT SERVICES ARE APPROPRIATE, IT HAS HAD THE EFFECT OF ENCOURAGING DEINSTITUTIONALIZATION AND THE USE OF LESS INTENSIVE SETTINGS. A PROVISION INCLUDED IN THE MEDICARE CATASTROPHIC COVERAGE ACT HAS FURTHER ENCOURAGED THIS TREND BY REDEFINING THE TERM IMD TO EXCLUDE FACILITIES WITH FEWER THAN 16 BEDS.

MEDICAID CAN PAY FOR SERVICES IN A RESIDENTIAL FACILITY OF ANY SIZE THAT IS AN IMD, BUT <u>ONLY</u> FOR RESIDENTS AGE 65 AND OVER. BECAUSE SUCH FACILITIES ARE NOT MEDICAID PARTICIPATING FACILITIES (LIKE HOSPITALS AND NURSING FACILITIES) THEY CANNOT RECEIVE PER DIEM RATES. HOWEVER, ELIGIBLE RESIDENTS CAN RECEIVE ANY MEDICALLY NECESSARY SERVICES AVAILABLE UNDER THEIR STATE'S MEDICAID PLAN, INCLUDING PERSONAL CARE SERVICES IN THE FACILITY.

OF COURSE, MOST HOSPITALS, NURSING FACILITIES, AND OTHER RESIDENTIAL FACILITIES WOULD NOT BE CLASSIFIED AS IMDS. IN THOSE THAT ARE NOT, MEDICAID PAYS FOR MEDICALLY NECESSARY CARE, INCLUDING MENTAL HEALTH CARE, FOR ELIGIBLE PATIENTS OR RESIDENTS, REGARDLESS OF AGE.

BECAUSE MEDICAID FUNDS ARE AVAILABLE FOR CARE IN A NURSING FACILITY, BUT GENERALLY NOT FOR CARE IN A FACILITY THAT IS AN IMD, THERE HAS BEEN CONCERN AMONG MENTAL HEALTH PROFESSIONALS, ADVOCATES, AND OTHERS THAT FINANCIAL INCENTIVES MIGHT LEAD TO INAPPROPRIATE PLACEMENT OF SOME MENTALLY ILL PERSONS IN NURSING FACILITIES. CONGRESS RESPONDED TO THESE AND OTHER CONCERNS BY INCLUDING A COMPREHENSIVE PACKAGE OF NURSING HOME REFORMS IN OBRA 87. AMONG THESE REFORMS ARE REQUIREMENTS FOR PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (REFERRED TO AS PASARR), WHICH ARE DESIGNED TO ANSWER TWO QUESTIONS FOR EVERY NURSING FACILITY RESIDENT OR PROSPECTIVE RESIDENT WITH A DIAGNOSIS OF MENTAL ILLNESS: (1) DOES THE PERSON NEED NURSING FACILITY LEVEL CARE; AND (2) DOES THE PERSON NEED ACTIVE TREATMENT FOR HIS OR HER MENTAL ILLNESS ?

IF THE PERSON DOES NOT NEED NURSING FACILITY CARE, THEN A MORE APPROPRIATE PLACEMENT MUST BE FOUND. ONCE SUCH A PLACEMENT IS MADE, THEN A MEDICAID-ELIGIBLE WOULD HAVE ACCESS TO MEDICALLY NECESSARY SERVICES AVAILABLE UNDER THE MEDICAID STATE PLAN, UNDER THE CONDITIONS I HAVE ALREADY DISCUSSED.

IF THE PERSON NEEDS NURSING FACILITY CARE BUT NOT ACTIVE TREATMENT, THEN MEDICAID PAYS FOR THE NURSING FACILITY CARE, WHICH MUST INCLUDE SERVICES TO MEET HIS OR HER MEDICAL NEEDS, INCLUDING PSYCHO-SOCIAL NEEDS. IF THE PERSON NEEDS BOTH NURSING FACILITY CARE AND ACTIVE TREATMENT FOR MENTAL ILLNESS, ADMISSION TO A NURSING FACILITY MAY BE MADE AND MEDICAID MAY PAY FOR THE NURSING FACILITY SERVICES. OTHER SERVICES MAY ALSO BE PROVIDED, PAID FOR EITHER BY MEDICAID OR BY STATE-ONLY FUNDS. THERE ARE TECHNICAL CHALLENGES TO IMPLEMENTING THESE PROVISIONS THAT RESULT FROM THE LANGUAGE OF OBRA 87; HOWEVER, I BELIEVE THEY ARE BEING ADDRESSED IN THE HOUSE BUDGET RECONCILIATION BILL.

MR. CHAIRMAN, I KNOW THAT YOU AND OTHER MEMBERS OF THE COMMITTEE ARE CONCERNED WITH IMPROVING SERVICES TO PERSONS WITH ALZHEIMER'S DISEASE. WE SHARE YOUR CONCERN. IN A PREVIOUS HEARING, YOU HEARD FROM THE NATIONAL INSTITUTE OF MENTAL HEALTH ABOUT THE DEPARTMENT'S RESEARCH EFFORTS ON ALZHEIMER'S DISEASE AND RELATED CONDITIONS. I WOULD LIKE TO ADD A FEW WORDS TO CLARIFY HOW THE NEW NURSING HOME REFORM PROVISIONS WILL AFFECT THOSE WITH ALZHEIMER'S DISEASE IN NURSING FACILITIES. PERSONS WITH ALZHEIMER'S DISEASE AND OTHER DEMENTIAS, WHO ARE BELIEVED TO BE A MAJORITY OF THOSE WITH MENTAL CONDITIONS IN NURSING HOMES , ARE NOT CONSIDERED "MENTALLY ILL" AND, THEREFORE, THEY WOULD NOT BE SUBJECT TO PREADMISSION SCREENING OR ANNUAL REVIEWS.

THIS DOES NOT MEAN THAT THEY WILL NOT BE APPROPRIATELY SERVED. ON THE CONTRARY, THEY, LIKE ALL OTHER NURSING FACILITY RESIDENTS, WILL RECEIVE NECESSARY MENTAL HEALTH, PSYCHO-SOCIAL, AND OTHER SERVICES UNDER AN INDIVIDUALIZED PLAN OF CARE.

CONCLUSION

THE MEDICARE AND MEDICAID PROGRAMS NOW PROVIDE MORE AND BETTER WAYS TO FINANCE MEDICALLY NECESSARY SERVICES FOR THE MENTALLY ILL THAN EVER BEFORE. THEY PAY THE COSTS OF IN-PATIENT INTERVENTION FOR ACUTE EPISODES COUPLED WITH FLEXIBLE OPTIONS FOR OUT-PATIENT CARE ON AN ON-GOING BASIS. THESE PRACTICES REFLECT BOTH PROVIDER AND COMMUNITY CONSENSUS OF THE MOST EFFECTIVE AND APPROPRIATE TREATMENT APPROACHES CURRENTLY AVAILABLE. WE ARE COMMITTED TO CONTINUING TO WORK WITH THE STATES AND THE PRIVATE SECTOR TO ENSURE THAT MEDICARE AND MEDICAID CONTINUE TO MAKE A SIGNIFICANT AND EFFECTIVE CONTRIBUTION TOWARD PROVIDING CARE FOR OLDER PERSONS WHO ARE MENTALLY ILL. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

SEP 8 [illegible]

The Honorable Edward R. Roybal
Chairman
Select Committee on Aging
House of Representatives
Washington, D.C. 20515

Dear Mr. Roybal:

Enclosed you will find responses to the questions raised by you as a follow-up to the August 3 hearing on mental health services to the elderly in nursing homes. We are in the process of analyzing H.R. 111 and should be able to forward our comments on the bill to you shortly.

Please let me know if I can be of any further assistance.

Sincerely,

Ross Anthony

C. Ross Anthony, Ph.D.
Associate Administrator
for Program Development

Enclosure

HOUSE SELECT COMMITTEE ON AGING

QUESTIONS AND ANSWERS FOR THE RECORD

1. Question

From your testimony, it appears that the 1987 Omnibus Reconciliation Act (OBRA 87) requirement of meeting patients psycho-social needs and restrictions governing Institutions for Mental Disease (IMD) place nursing homes and their patients in a severe bind. If nursing homes provide active treatment, they are likely to be re-classified as an IMD and lose Medicare reimbursement. If they don't, they violate the 1987 law and fail to help mentally ill patients. How do we get out of this bind and help patients?

Answer

It is true that the Medicare and Medicaid programs do not provide payment for care in every possible type of facility for every individual. While the IMD restriction applies to both programs, it is generally considered to be more of an issue for Medicaid because that program funds long-term care while Medicare limits the duration of stay in skilled nursing facilities to a maximum number of days per year. OBRA 87 requires both the appropriate placement of individuals in nursing facilities and appropriate treatment of their needs, including psycho-social needs, once they are there.

While it is certainly possible for a nursing facility to be classified as an IMD, the regulatory definition of IMD makes clear that such a facility is "...an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.... Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases...." (Emphasis added.)

The fact that many nursing facilities will have one or more patients who require and receive mental health services of some kind, including some who may require and receive active treatment will not, in and of itself, cause them to be classified as IMDs. We expect that most nursing facilities would not have the overall character of an IMD and, therefore, would not be classified as such. For those few that are, Medicaid can still pay for the care of individuals over age 65, if the State elects that option. Medicaid can also pay for a range of ambulatory mental health services and for in-patient hospital care in the psychiatric unit of a general hospital for those under age 65, if they were transferred from an IMD to another type of living arrangement, such as a group home of 16 beds or less.

2. Question

Given the problems created by the Institution for Mental Disease (IMD) rule for those over age 65 and those under age 65, would the Administration support changes that would allow active treatment, and would not penalize nursing homes with specially trained mental health personnel as long as 50 percent or more of the patients have a physical condition requiring them to be in a nursing home?

Answer

As we discussed above, the IMD definition imposes no Federal restrictions for those over 65, and provides alternative ways of providing Medicaid-funded care for those under 65. The IMD rule is not directed toward limiting the type of services people receive, but rather who will pay for them. However, it has had the effect of encouraging deinstitutionalization and care in less intensive settings, which most mental health professionals agree is the preferable approach for most persons with mental illness.

Federal law requires States to determine whether every individual needs nursing facility level care by defining a nursing facility, for Medicaid purposes, as an institution which "... is primarily engaged in providing to residents... on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases...." We do not believe that any useful purpose would be served for those with mental conditions by including a percentage in the definition or by limiting it to physical conditions. The present definition already clearly indicates that persons with mental conditions can be patients in Medicaid-funded nursing facilities.

The extensive revisions to Federal nursing facility law in OBRA 87 will mean that nursing facility participation requirements and inspections focus upon assuring that nursing facility patients not only are appropriately placed, but receive the services they need, including mental health services. Such services can be provided by any appropriately trained persons, whether they specialize in mental health or are generalists with appropriate expertise, whether they are on the staff of the facility, are brought in from outside as consultants or contractors, or patients are transported out to another facility for services. We see no advantage to trying to limit the flexibility of nursing facilities in how they may appropriately arrange for mental health services for patients who need them.

3. Question

Given the great need to get more and better health care into nursing homes, does the Administration support the extension of direct reimbursement to clinical psychologists, clinical social workers and psychiatric nurse specialists?

Answer

A change in the law could be interpreted as a relaxing of provisions in current law which give responsibility for the overall assessment and direction of patient care to physicians.

The Administration opposes any provision that would allow clinical psychologists, clinical social workers and nurse specialists to be reimbursed directly. We have no indication that patients needs are not being met under the current payment structure. In addition, we believe direct payment could result in increased expenditures and duplication of services.

Notwithstanding these overall concerns about proposed legislation, it is worth noting that services of these specialists are already covered in nursing facilities when provided by the facility. Thus, no matter what legislative result may occur with respect to this proposal, residents of long term care facilities will have access to covered care by these health care professionals.

4. Question

Under current law, Medicare's 50 percent coinsurance for mental health benefits virtually eliminates access to lower income beneficiaries. Would the Administration support a change in the coinsurance to 20 percent like the rest of Medicare benefits?

Answer

We believe the higher coinsurance amount is consistent with similar limits imposed by private health insurance companies in controlling utilization of outpatient psychiatric services.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 will take care of those qualified Medicare beneficiaries (QMBs) with income up to 100 percent of poverty. States will have to pay their part A and part B cost-sharing expenses. There are expected to be 600,000 QMBs in FY 1990 and 1.2 million by the time all of the QMBs have been phased-in.

Medicare beneficiaries who are not QMBs are likely able to afford the coinsurance and therefore adding the costs of the Federal budget at this time is a questionable priority.

5. Question

What assurances can you and the States give us that the Preadmission Screening and Annual Resident Review (PASARR) will not result in "no-care" patients who have a mental illness but are refused admission to a nursing home and receive no care in the community?

Answer

We can only give you assurances with respect to the Medicare and Medicaid populations. Your question seems to assume that individuals refused admission to a nursing facility would have no access to other services. In fact, as my testimony pointed out, Medicare and Medicaid cover certain in-patient and a wide range of out-patient services which may well address many of the needs of a person with mental illness. We hope that States will use the many options available to them under current Medicare and Medicaid law, in combination with their own resources, to develop an array of mental health services. Indeed, a number of States are doing just that. Many of them are combining Medicaid services, group homes, and services from other Federal and non-Federal sources into innovative solutions to these service needs.

Mr. ROYBAL. Thank you, Dr. Anthony. First of all, I'd like to express my appreciation for your attendance and for your patience in waiting until this time to present your testimony.

I think it is important for the committee to know how the administration proposes to ensure Medicare beneficiaries do not lose access to their Medicare mental health benefits the day they enter a nursing home. What is being done with regard to that? What is the administration's position?

Mr. ANTHONY. Under the PASARR program, the fact that you enter a nursing home does not change your eligibility for the Medicare or Medicaid programs. In the case of Medicare, you are eligible, in general, by virtue of having reached age 65. Now, there are certain limits in the Medicare program. However, as I understand it, particularly after the catastrophic bill, access to mental health benefits under Medicare should not be impaired by the fact that you might be admitted to a nursing home.

Mr. ROYBAL. If they do not receive mental health services in a nursing home, then they have to go to some other project, do they not?

Mr. ANTHONY. I think you're referring to the requirements under the new PASARR guidelines.

Mr. ROYBAL. Right.

Mr. ANTHONY. Under the recently passed law, what happens is—as I think others indicated—people must be screened to determine whether or not they have mental illnesses. We've tried to organize that screening in a way that is least onerous upon the facilities yet has the effect of finding out which people have mental illness.

Once that screening takes place and, in fact, it is determined that person—whoever it is—has a mental illness, then that person could be admitted to the nursing home but only if the nursing home is capable of providing the services that are necessary to serve that person under his plan of treatment.

Now it gets a little more complicated. If the person is admitted to the nursing home, Medicare does not pay for so-called "active treatment", although Medicare requires that the psycho-social needs of the person be met. There's a certain overlapping of these two terms sometimes that can become confusing.

If the person is in need of active treatment, it must be provided, but it cannot be paid for by the Medicare program.

However, under the Medicaid program, if another agency such as the State provides the active treatment to the person in that nursing home, then that would be an expense that could, under certain circumstances, be shared by the Federal Government if the person is eligible for Medicaid.

Mr. ROYBAL. But if this service is not paid for, what happens?

Mr. ANTHONY. Let's say that the person is not admitted to the nursing home because the nursing home, for instance, does not provide those services. It is our expectation that the person should receive those services, and usually that would happen, as I think was indicated by the gentleman from Indiana, in some other State-related program.

Mr. ROYBAL. Isn't it true that if they are not admitted to a nursing home, then most of the time they receive no care in the community?

Mr. ANTHONY. I honestly can't speak to what the statistics show. I think that would be something to find out very clearly. It's my understanding, as was indicated earlier, that, in fact, they do receive treatment somewhere. I really don't know exactly where most of them receive that treatment.

Mr. ROYBAL. There's a vote on the Floor so I will have one more question I want to ask.

Mr. ANTHONY. Certainly.

Mr. ROYBAL. And that is that under current law, Medicare is 50 percent coinsurance for mental health benefits, this virtually eliminates access to lower income beneficiaries. Is that a correct statement?

Mr. ANTHONY. I think it's a bit strong. Certainly the fact that there is a copay of approximately 50 percent inhibits access to care by certain individuals. I think the other side of the coin is where the elderly person would be truly low-income, then they could become eligible for Medicaid—under the Qualified Medicare Beneficiary program—and, therefore, eligible for those benefits.

The area of greatest concern is the area where the individual has enough money so that they are not eligible for Medicaid and yet are on the lower-income end of the Medicare-eligible population. That's a concern that I think the Congress, the administration, and others have expressed, in a whole wide range of services that go quite beyond the mental health benefit. There are a number of commissions, including the Pepper Commission, and also the Quadrennial Commission, that are presently looking at this question of access to health care for a whole range of different groups.

Mr. ROYBAL. In other words, you agree that there's a great deal that has to be done?

Mr. ANTHONY. I don't think that anybody who stands up here, no matter who they represent, can say that we have gone as far as we need to go in this country in terms of improving and trying to perfect the health care benefits and insurance programs that we offer. I certainly wouldn't. Unfortunately, a lot of the changes are expensive, they involve very complicated trade-offs, and I, frankly, sympathize with Members of the Congress who oftentimes have to wrestle with these trade-offs in terms of benefits. And to the extent that we can provide you with information and responsibly enter into a dialogue to help you, we stand ready to serve.

Mr. ROYBAL. Dr. Anthony, again, time is passing rapidly. I wish I could discuss this further with you, because I still believe that the need is so great that what little is being done is definitely not enough.

Mr. ANTHONY. Yes, sir.

Mr. ROYBAL. Now, we in the committee attempt to remedy certain situations. I have this bill, H.R. 111. I would like to give you that bill and get your ideas as to how that could be improved.

Mr. ANTHONY. If you give us a copy, we'd be glad to submit some comments for the record.

[The information follows:]

EDWARD R. ROYBAL, CA
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November 21, 1989

C. Ross Anthony, Ph.D.
Associate Administrator
for Program Development
Health Care Financing Administration
200 Independence Avenue, S.W. Room 617F
Washington, D.C. 20201

Dear Dr. Anthony:

As you may recall, on August 3, 1989, you testified at the House Select Committee on Aging and the Subcommittee on Human Services hearing entitled, "Mental Health in Nursing Homes: Barriers and Solutions." On September 8, 1989, you informed our staff that your office would forward your comments on H.R. 111 "shortly". Since the Congress is recessing in the next couple of days we find it no longer possible to keep the record open. Your staff was notified of this action on Friday, November 17, 1989.

Sincerely,

Edward R. Roybal
Chairman
Select Committee on Aging

Thomas J. Downey
Chairman
Subcommittee on
Human Services

Mr. ROYBAL. I thank you very much.
Mr. ANTHONY. Thank you, sir.
Mr. ROYBAL. I thank you, Dr. Anthony, for your testimony.
The committee is now in adjournment.
[Whereupon, at 12:40 p.m., the joint hearing was adjourned.]

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